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Mr. Chairman, Members of the Iowa State Medical Society, Ladies and Gentlemen: From time immemorial it has been the privilege of the presiding officer of this and like societies to deliver an address which is the reflection of living issues as seen by him. Guided by this custom, I shall review a few questions as seen from my point of observation, and through such glasses as I may wear. But first let me assure you that I can not express the great appreciation I feel because of the high honor conferred on me one year ago. The honor came unsought, hence all the more precious, and all the more appreciated. I was so happy in my membership, was having such a good time, so heartily enjoyed and so much profited by the meetings, that I never gave this high office a single thought. I have one burning wish, that I may continue an active worker in the ranks, I hope to be more interested in the welfare of the society than ever before. If I have ever been a useful member, I hope to be more useful in the future. I thank you all from the bottom of my heart for the many tokens of affection I have received from you, not only during the past year, but also during my illness of several years ago. It was during that illness that I learned better than ever before that doctors were a red blooded, big hearted lot of fellows, and that it is good to be one of them. I thank you again.

The Iowa State Medical Society.

The Iowa State Medical Society has reason to congratulate itself on the spirit of good fellowship that has characterized its meetings in the past. I do not believe that there is another medical society in the United States in which the members are less influenced by selfish motives than in this society, to which you and I have the honor to owe allegiance. In the Iowa State Medical Society, fellow members, we do not know the meaning of the word politics. We have no factions, no cliques, no ins, and no outs. What is best for the society, is the one question ever at issue. So long as this happy state of affairs con-

tinues, and I believe that it will continue always, the Iowa State Medical Society is sure to make rapid progress in the fulfillment of its mission.

It has sometimes been said that it is difficult to secure a place on the program of the annual session. Nothing can be farther from the truth. I assure you that the program committee and the various chairman are anxiously looking for the very best men to read papers. If the best men are not secured, it is because they are not known. If any member wishes to read a paper before the society, let him on several occasions discuss thepapers of others. If he do this well, he is a marked man, and from that time on it will be impossible for him to keep off the program. It is to be regretted that the scientific program can not be published at least two months before the meeting, to give ample opportunity for every member to prepare himself thoroughly on several of the subjects that are coming up for discussion. Desirable as this should be, it is not an easy matter to accomplish.

The House of Delegates.

To confide the business of the society to a small body of men known as the House of Delegates is a wise provision of the plan of reorganization. It is sometimes said that the society is not really a democratic body, that its affairs are managed by a relatively small number of men. There is a little truth in this statement, and it will continue to be true until county societies elect delegates that will attend the session, and that will attend all the meetings of the House of Delegates. Sometimes at the meeting of the third morning of the session there is a bare quorum present, and of those present many are in attendance as delegate for the first time. Naturally those that know what should be done and how to do it, are very apt to point the way. To make the business end of this society truly democratic, to give every county a voice in the business affairs of the society, send as delegates members that will attend the meetings, that will familiarize themselves with the needs and the working methods of the society, and having found such members return them year after year. To be a delegate means work and honor. The member that considers only the honor and shuns the work will never make a good delegate.

I believe it would be a very good plan for all county societies to hold the annual meeting for the election of officers during the month of December. The delegate selected would thus have ample opportunity to familiarize himself with the needs of the society. The name should be sent to the secretary of the State Society sufficiently early to make possible a correct list of delegates in an early issue of the Journal. There can scarcely be any objection to this plan, and there is certainly much in its favor.

The Journal.

The House of Delegates, at the 1911 Session, in Des Moines, passed a resolution authorizing the Board of Trustees of the Iowa State Medical Society to take over the advertising of the Iowa Medical Journal, but at no time had the Iowa Medical Journal indicated a willingness to accept the offer made by the society, and later decided not to do so. Hence the Board of Trustees established the Journal of the Iowa State Medical Society, an act entirely acceptable to all parties concerned.

Owing to a ruling of the Post Office Department, this new Journal was not permitted to carry advertising without paying a rate of postage so high as to leave little profit on the advertisements carried, and the new Journal was started without advertising. Later, the Post Office Department so modified its ruling as to permit advertisements in the Journal, provided the subscription price of the Journal be not included in the annual dues, but is kept separate, and optional. Arrangements to carry advertising are now practically complete, and advertisements will soon appear, which will very materially lessen the cost of the Journal.

I feel that the Journal of the Iowa State Medical Society has been a great success. The editorials have been forceful and to the point, and have correctly and lucidly represented professional sentiment on the living, and I might say, the burning questions of the day. The scientific matter has been good, as was to be expected from the list of contributors. Excellent as has been the record of the Journal during its first year, I am sure that it will continue to improve with each succeeding issue, and that it will attain high rank among the State Journals of the country.

However, I can not refrain from making one little suggestion. I believe that the annual session of the State Society should be featured in the April number of the Journal, and that everything pertaining to that annual session should, so far as possible, be front page matter.

County Societies.

The county society occupies a high place in the factors that make for individual and collective progress. In fact, I firmly believe that the work of a county society is a correct index of the professional attainments of its members, and of the character of the service rendered the public. A dead county society means that it is not fulfilling its mission. In order to improve, to keep abreast of the times, medical men must frequently meet in convention to discuss medical topics. No statement needs less corroberation than this, so evident is its truth. These meetings reciprocally stimulate. It is so often said that physi-

cians should join medical societies and do society work to improve the medical profession. I feel very much like saying that physicians should join societies and do society work to improve themselves. Let the motive be selfish, let it be self improvement, because whatever improves the individual improves the entire profession, and the quality of the service rendered the public, and hence makes for public good. I am almost ready to confess that I attend medical societies for selfish motives. I always hear something that sets me thinking, that stimulates me to better effort, that makes me try to be a better doctor. I do not attend meetings with the thought of improving the profession. I am not so conceited as to imagine that my presence is essential to the common good. To imbibe new ideas, to receive inspiration, to enjoy the fellowship of my co-workers, these are my motives.

The county society is most important because its meetings are held frequently, and because it gives practically every member an opportunity to take an active part. If the members regularly attend the meetings of the county society, read papers as often as the program committee will permit, and always prepare themselves to discuss the papers presented by others, the meetings are sure to be profitable, not only to the individual, but to the entire professional body. The program committee of the county society should always invite case reports, these reports to be carefully prepared and accompanied by a brief review of the up-to-date literature on the subject. Simply to report a case without such careful study is not very profitable either to the member making the report or to the society. The best way to stimulate interest in medical society work is to have interesting and frequent meetings. It is so much easier to prepare a program a month or two months in advance, and if the subjects be announced at least one month in advance every member will have an opportunity to prepare himself to take an active part in the discussions. Every member is interested in the meeting in which he takes an active part. He feels that it was a good meeting, just as the old lady insisted that the prayer meeting was a most excellent one, because she lead in prayer. In this state there are several county societies that will serve as models, notably in Ottumwa, Centerville, Ft. Dodge, and Lisbon. These societies arrange their meetings months in advance. A little group of men at Lisbon, Linn County, has met every two weeks for the past two years, sometimes with but three (all the doctors in the town) in attendance, sometimes with quite a number of doctors from neighboring towns. The meetings have always been interesting, and they have resulted in much benefit to those that took part. The work of the medical men of the little town of Lisbon may well serve as an example of patient, persistent, and successful county society effort. A county society which

meets but once or twice a year, or which mails its program one or two days before the meeting, is valueless so far as benefiting its members is concerned.

The ideal method of conducting society meetings is that adopted by the Wapello County Society. In this county the program for the entire year is prepared and printed at the beginning of the year, and issued in a neat little pamphlet. I should urge every county secretary in Iowa to write Dr. J. F. Herrick, of Ottumwa, (Wapello County) for pointers on County Society work. There can be a very good county society wherever four or five doctors can get together once or twice a month. I am not very enthsuiastic over members that simply pay their dues but never attend the meetings. Personally, I consider them dead, lying high and dry on the bank, and far from the busy stream. Their annual dues are accepted, but they do not stimulate their fellows and are not stimulated by them, they neither give or receive, they are ciphers in the society and society work, and almost invariably dead ones. I wish to say here that a county secretary that fails to send a written invitation to each member of the society immediately after his election, asking when it will be convenient for that member to make his annual scientific contribution to the society, and who further fails to mail the program at least one month before the meeting, is inefficient and incompetent and ought to receive the treatment that the food fakers planned for Dr. Wiley.

The program should be mailed a few days before the meeting, but each program should, in smaller type and in less conspicuous display, carry the program of the following month. Better still to have each program announce the papers to be read the two following months. It stimulates the writer of a paper to have it known that he is under observation, it makes him feel that something is expected from him. This plan gives others ample opportunity to prepare their discussion. I again call attention to the Ottumwa (Wapello County) plan which is best of all.

It has been said that there are too many district societies that detract from the county society and from the state society. Personally, again, I do not share this opinion. I believe that the men that attend the district societies are the most regular in attendance and the best workers in the county society, and most active in the state society. However, I am most firm in my conviction that membership in the state society should be a necessary qualification for membership in every medical society. I do not believe in the so-called "free lance" societies. The more good societies the better. Let a doctor get the medical society habit and he is always in attendance at his county, district, state, national, and special societies, but of these the county so-

ciety is most important, because it does or should meet at least once each month.

Medical Defense.

For some years the State Medical Society has defended its members when wrongfully sued for alleged malpractice, and this phase of society work has been taken up in twenty-two other states. It is sometimes said that malpractice suits are often secretly encouraged by unprincipled competitors, or by so-called experts for a fee. That this is sometimes true can not be denied, but, sometimes, I fear these suits are due to an uncompromising attitude on the part of the doctor in the presentation of his bill for services. It must not be forgotten that, no matter how just the claim for services rendered, even a successfully defended suit for malpractice is a very expensive procedure in time, money, and reputation, and that its cost will more than offset the fee involved. There is no such thing as getting glory out of a suit for malpractice. The doctor, even if the case be taken from the jury, is sure to be blamed by a certain number of people in the community. It involves an unpleasant, distasteful notoriety. Good advice is, do not resort to the courts to collect a fee, if by so doing a malpractice suit may result, unless your management of the case will stand the severest criticism. Do not indirectly invite a suit for malpractice simply to vindicate your position. The medico-legal committee was called upon to defend a $15,000 suit where the patient offered to pay $60 and the doctor insisted upon $75, and here they stuck. This suit cost the society several times the amount of the original bill, and was finally dropped, the doctor collecting his fee in full. But I do not believe that he is the gainer by the transaction.

To prevent suits, whenever the case is such that the result at the best may not be satisfactory to the patient, secure early and efficient consultation. If there is a possibility, however remote, that the case may be the cause of trouble in the future, secure still more early and efficient consultation, do not wait until the patient requests you to seek additional advice, suggest consultation yourself even before beginning treatment. All fractures should be seen by a second doctor, the best doctor within call—all of them should be "X-rayed" before and after setting, and on discharge. In all fracture cases, the patient should receive specific instructions, nothing should be left to chance. If the patient be asked to report at a certain time, let the record show whether or not he did so. There must be fewer malpractice suits, or the society will have to raise its dues very materially.

The medico-legal commitee has never concerned itself with the defense of any member unless said member was unjustly sued, but I think I may say that, in some instances, a little more discretion on the

part of the doctor, or a consultation, would have avoided the trouble entirely. Do not forget that a successfully defended suit for malpractice is expensive in time, worry, and reputation. It is far better to go a long way round to avoid one.

HOSPITALS.

Hospitals are increasing in numbers and should be most important aids in securing the best treatment for many conditions. But too often they are but very poorly equipped for the work undertaken. Too often the visitor is shown a magnificent operating room, while the all but mythical laboratory is located only with difficulty. X-ray work is poorly done, bed side notes are but poorly kept, the instruction to nurses is not systematic or serious, and the pathologist and the bacteriologist are honorary gentlemen, rarely on duty, and who make occasional examinations and who, forsooth, do their work in a private office instead of a well equipped hospital laboratory. A well equipped hospital laboratory is absolutely necessary, without it a hospital may be a boarding house for the sick, but it does not make for progress. Every case entering a hospital must be most carefully studied, ante and post operationem, ante and post mortem, and in the words of Murphy "Let the record show what was done." I consider a careful and complete record most important. This record must contain the clinical diagnosis, the operation findings, the pathological diagnosis, and a careful bed side record. Such records kept permanently in the hospital and subject to inspection would make for better and more honest work. In many hospitals there is absolutely no systematic attempt at improvement, the hospital board is either too soundly asleep or too actively engaged in intramural hostilities to think of the scientific side of hospital work. Nothing so effectually paralyzes a hospital as a somnalent hospital board, and such a board should resign. Sleeping sickness in a hospital board is incurable. In surgical work, too often it is cut and cover, the mistakes are not honest mistakes, such as competent painstaking men make, and which make for progress. Too often hospitals are tainted with the same spirit of commercialism that is so often seen in medical ranks. Too often they are so anxious to fill their beds that they do not inquire into the character and efficiency of the doctor that would treat a patient in the house. No policy can be more short sighted. The reputation and the success of the hospital depends on the character of the work done, and only such physicians should be permitted to work within the walls of a hospital as are able to add to the reputation and standing of the hospital. I believe that there should be a juinor and senior staff, the members of the junior staff to be under supervision until they have demonstrated their fitness to assume critical responsibility. Every legal, honest prac-

titioner should be given the opportunity to demonstrate his ability, but if after reasonable opportunity it becomes evident that he is morally and professionally unqualified, the senior staff should have the authority to deny him further admission to the hospital. I consider this all important. A man known to be dishonest, or of a judgment so warped that he does a gastro-colostomy as an operation of choice, or who does a hysterectomy on a young woman and proudly exhibits the "specimen," a submucus fibroid which in no manner necessitated a sacrifice of the uterus, or who commits a criminal act inside or outside of the hospital, should be forever barred. I am pleased to report that there are some hospitals in Iowa that bar men like the above. Would there were more.

The operating room should be open to members of the staff at all times. Of course, every attendant witnessing the operation of another is bound by the most rigid obligation to preserve professional secrecy, the same as if the patient were his own. In this way the limited number of operations in a small hospital could be seen by all, and the sum total of the experience of each member of the staff would be very considerable. On the one hand, camera obscura methods should not obtain in a hospital; on the other hand, professional secrecy must remain inviolate. Interesting cases of all kinds should be studied for the benefit of both patient and staff.

I believe further, that the day is past when medical men can be attending physicians and attending surgeons. They should be attending physicians or attending surgeons. So long as practitioners of medicine attempt to cover the entire field, so long will work be poorly done. No man can be a physician and a surgeon.

Let us get over the idea that the surgeon has the larger brain with deeper convolutions. It is true, his successes and his failures are more in evidence, but the correct management of an anemic, illy nourished child; the correct management of a summer diarrhoea; the correct management of a case of pneumonia is a task which even the best should feel proud to have done well; and the man that manages these cases well, that by training and nature is fitted to do them well, is not fitted to do surgery, and equally, the man that with a few movements of the knife is in the habit of accomplishing much, is not fitted for the patient, persevering work of the internist, although he must be a good diagnostition. I believe that the movement to standardize all hospitals should be encouraged by every means possible. Minnesota has taken the lead, and a nation wide movement is being considered by the Council on Education of the American Medical Association. I believe that the hospitals of Iowa will welcome this movement. A hospital is a public utility, the public is vitally interested, and has a right to know that it is

well managed. All hospitals should be placed under searching and rigid state or national supervision. Standard hospitals would be available as clinical schools for the instruction of fifth year students. What an immense impetus to better endeavor. The public would soon recognize the difference between a standard hospital and one that is not standard, patients would seek the former and avoid the latter. Let us have well managed standardized hospitals, where team work is done, where specialists are developed, where only high grade men are admitted, and where the incompetent and the dishonest are barred. Let hospitals become each a medical school where there are equal privileges for all honest, earnest, reasonably competent men. But, I repeat it, to work in a hospital must be considered a privilege, a badge of honor, and the unworthy should not enter. Who shall decide the question of fitness? If the work of a man will not bear the light of day, if his work is not open to inspection by his colleagues, if the record, an honest record, does not show what he has done, let him be barred.

I wish to make a plea for a trained resident Roentgenologist, pathologist, and anaesthestist in hospitals. It is becoming quite the correct thing to have the anaesthetic given by trained women. Such a woman, resident in the hospital, could give anaesthetics, act as pathologist, do X-ray work, etc. There is ample work about a hospital of very moderate size to keep such a trained woman quite busy, to the great advantage of every member of the staff. A pathological report in every case would stimulate to better effort and make for better doctors.

Commercialism in Medicine.

This word commercialism has a harsh and resping sound, but it will not down, although its discussion usually makes for progress, as the crab progresses. Books have been written on it (Norman Barnesby, "Medical Chaos and Crime"); there have been biting magazine articles without number, (notably by Arno Dosch, Ex-President Reed of the A. M. A., both in Pearsons) many articles in medical journals and numberless addresses by medical men before medical bodies. The remedy for existing conditions has been sought in publicity; laws to control it have been threatened, dire laws, unless the medical profession eradicated the evil: "Purify yourself from within or you will be purified from without, and to your sorrow." The result has been more and more commercialism, until the public thoroughly distrusts the medical profession, a distrust on which arrogant quackery has fattened as never before. What good does it do to talk about these things? But the subject will not down, until the medical profession mends its way, and public confidence is restored. Too much has been said and written to "put on the lid" now. I shall not enumerate the various

symptoms of this disease, commercialism, as manifested in the body professional. This is a commercial age, and it is little wonder that the medical profession has not escaped. In truth, to have entirely escaped infection, would mean that medical men and women are made of much sterner and purer stuff than other men and other women. "Put money enough in thy purse" is the almost universal slogan.

In defense of commercialism in medicine, it has been said that medicine is a business, and business methods should prevail. A business man has something to sell, and he sells to all that he can induce to buy, his only concern being the ability of the would be purchaser to pay, and his own profit on the transaction. It is not for him to inquire whether the would-be purchaser needs the article offered, or whether its acquisition will add to his happiness or comfort. Imagine a physician or a surgeon influenced by the same considerations, "ability to pay and the profits on the transaction." How often have you, members of this society that are not tradesmen, how often have you refused to sell your commodity in spite of the fact that the consumer had a good financial rating, and the profits of the transaction were within your grasp; how often have you refused to give unnecessary medicine; how often have you declined to do unnecessary operations; how often have you sought your reward not in "honesty is the best policy" but in the feeling that you were doing right, regardless of the most profitable policy! The practice of medicine is not a business, except to the charlatan and the quack. What sort of business man would unceasingly labor to destroy his market and curtail his sales, as does the physician who tries to prevent disease and the spread of infection. But I fear that there may be physicans that are tradesmen, that barter, that sell their wares to all that are willing to buy, to whom a patient is only a possible source of so much profit, as much "as the traffic will bear." I do not believe that any such are attending members of this society. The relation between physician and patient is not that of buyer and seller, it is unique, unlike that of anything else on earth. As was recently said in an address to medical men "You are the prosecuting attorney, you are the counsel for the defense, you are the judge, you are the jury, and you are, sometimes, the executioner." And I shall add: "You conduct your case behind closed doors, in camera obscura, with no witness but your own sense of right and wrong." And this profession of ours is a business, subject to business methods! I tell you it is a vocation calling for the highest ideals and for the most unselfish standards of honesty and purity of purpose. No, we are not tradesmen, you and I. But if it be true" that those that preach the Gospel shall live by the Gospel," it must be fitting that those who practice medicine should live by their labors.

Business methods in making collections does not make our profession a business; and here a business spirit, a tempered business spirit, should prevail.

But the struggle for existence goes relentlessly on and the spirit of commercialism is the result of an inexorable law. As the struggle for a livelihood becomes more intense, men are less concerned about methods, provided the desired end be obtained. No fact is better known in the business world than that competition may be so acute as to be ruinous to the competitor, and give a very inferior article to the consumer. Worse still, the material rewards may be so meager that the better class of young men will not be attracted to the profession.

What can be done to remedy this evil? Before a remedy can be suggested for this condition, something must be known of its source, of the factors which brought it about and which give it root. Back of all and responsible for all is a condition from which there is no immediate escape. There are too many medical schools, too many commercial medical schools, and consequently too many doctors and especially too many that are graduates of commercial schools. The remedy that suggests itself first of all, is to lessen the number of medical schools, and to eliminate all of the commercial schools. There is no other possible solution. Yellow fever was throttled by destroying the breeding places of the mosquito: by screening the rain water, oiling the ponds, or draining the swamp land. In like manner must the breeding places of the incompetent and commercial doctors be sought out and made impossible. All the commercial medical schools must go, all the struggling medical schools must go, medical schools harboring commercial teachers must purge their faculties or forfeit the support of the profession. Commercial teachers in medical faculties are doing and have done more to commercialize the profession, and I use the word commercialize in the worst possible sense, than all other factors combined. With these men prostituting their positions for the most selfish of ends, improvement is impossible. The struggling and honest school may deserve sympathy and the coup de grace should be given it as considerately as possible, but it must be *coup de grace*. If for any reason a school does not promise the best results, it must go. Let the good and the poor schools be advertised for just what they are, let prospective students know which schools are good and which are bad. Students must learn more about work in medical colleges. They must learn that it is an easy matter to keep them busy in almost any kind of a medical school, to keep them "hustling," they may have no time to compare notes. Naturally, the ambitious, industrious student feels that his time is profitably spent because he is busy. He is not a judge of the quality and food value of the viands set before him, he often gets very

little wheat in much chaff, so that he is kept very busy getting enough protein to keep growing, his stomach is taxed to the utmost, but the food value of the repast is very low, his real advance is but a fraction of what it should be in the four or five years of his course. If the best schools be selected, and this would be done if the best schools were known to those entering, much would be done to solve the problems now confronting us. Doctors should advise young men to select only the better schools, should help them select the better schools.

The State Board of Medical Examiners, a National Board, or a Board for a group of states, must insist on more rigid examinations of schools and of applicants for license. It may be necessary to improve the quality of the board. In fact I think it is most advisable to do this, by asking the State Medical Society to suggest two or three names for each vacancy on the board, the governor to make the final selection. There should be no bar to reappointment on the board, because really good men are very few. Boards must carefully acquaint themselves with the work actually done in medical schools. Let them carefully inspect the schools, actually know whether that old worthless gynecological clinic is still being given, whether that "favorite pastime of former medical students" the omnibus spectacular surgical clinic, worthless except for diagnostic purposes, is still in vogue, or whether individual painstaking instruction is being given to small groups of students. Let the state board know that clinical material is ample, that selected cases may be available for demonstration when needed. When the candidate reports that he has attended five cases of confinement, let the board know whether the five cases sufficed for one hundred students seated on the benches, or whether each student individually attended five cases, let the board know whether one hour by the teacher means one hour for one hundred students taken collectively, or whether it means one hour for a small group of five students. The board must take nothing for granted, let it actually and seriously investigate, and know that candidates have had serious individual, not omnibus training. Two years in college as an entrance requirement may mean something or it may be a blind, the actual work in the medical course is more important than the entrance requirements.

Let the board give a practical as well as a theoretical examination. The present examinations are not a test. A man may answer ten questions on almost any subject, with the aid of quizmasters or quiz manuals, and still be utterly incompetent to practice medicine, woefully ignorant of medicine. It is a very poor school indeed that can not prepare its graduates to pass examinations as at present conducted. It is said that years ago a certain medical school in the South, with

a one year course, had more men in the army and navy than any other half dozen medical schools. The graduates were prepared to pass examinations. That school is now a four year school, but I question whether its recent graduates are better able to answer questions than were the graduates of years ago, although they are infinitely better prepared to practice medicine, infinitely better doctors. The work of the state board will be very easy in those states which have no medical schools within their border. In such states both the theoretical and the practical examinations can be made very severe, the number of physicians gradually lessened, and the service to the public immensely benefited. Such a state should be especially fortunate, it should have the best medical service, other states bearing the heavy cost of educating its medical men. There would be no local interests to consider.

In states which have within their border weak and struggling medical schools, the profession has confronting it an unusually difficult problem, since the examinations are sure to be tempered to meet the ability of the home school. Deplorable indeed is the condition in a state in which there are many commercial schools of the lowest type, and in which the state board is controlled wholly or in part by these schools. This condition seems to exist in one great commonwealth, and it is a satisfaction to know that the Iowa State Board and other State Boards have established a quarantine against that state, and it was time. The odor was smelling to Heaven, and it will take a generation to remove the blight.

With fewer and better schools, better examinations, with at least one year of hospital training, there will be fewer and better doctors, and the medical profession will attract better men. This much attained, professional fees must be equalized. Who will maintain that the correct management of a case of pneumonia, typhoid fever, or summer complaint in a child requires less skill and thought than an ordinary laparotomy. Is the fee adequate for the services in these cases? Fees for the trying house to house service, be it in the country or in the city, are too low. Do you wonder that so many medical men are attracted by the larger fees of the operators? The well trained experienced surgeon that makes careful diagnoses, that is competent to meet emergencies, that does every operation in the best possible manner, that is conscientious and God fearing, that declines to do unnecessary operations, that does enough but not too much, that man earns his fee whatever it may be; his fee is not easily earned, he is the ballot dancer that so easily and so gracefully stands on her great toes, it is easily done, at least it seems easy, but try it. It took that girl years and years of patient effort to do that apparently simple trick well. She is the surgeon that so easily earns his fee. We are attracted by the

things that seem easy, we neglect the things really difficult, as the correct diagnosis, and the correct management of daily internal cases. And why? It is the fee that is attractive. With fewer and better doctors, with fees proportional to the skill and the judgment and the responsibility involved, conditions will be immensely improved. A doctor must be able to earn enough to educate his chlidren, to take needed rest, to visit medical societies, and medical centers, to be able to look old age and possible infirmity in the face without dread or fear.

Can anything else be done to improve conditions? That question has been answered many times, it has been answered by Norman Barnesby, by Ex-President Reed of the American Medical Association, by Ex-President Lord of the Western Surgical Association, by President Murphy of the American Medical Association, any many others, and that remedy is included in the single word "publicity." Let the people know that at least twenty-five per cent of the men practicing medicine are graduates of commercial schools and entirely incompetent to assume responsibility of any kind, be it teething baby or a case of round worms. There are men that are equally incompetent, although graduates of schools considered good at the time of their graduation. I refer to the men that have not visited medical centers during the past ten or fifteen years that do not read journals, whose diagnoses and operations beggar description.

The "amateur surgeon" has been flayed without mercy, and he deserves all he is getting, but he is not so much to blame as the school which failed to impress him with the sacredness of his obligations, and the state examining board that gave him his diploma and his license to assume every responsibilty. In this address the word "amateur" does not consider the age of the surgeon, or the years of his practice. The man that does not often feel that his knowledge of surgery is very incomplete and that does not persistently seek the truth, the man who does not make every effort to reach a correct diagnosis in every case is an amteur, and should be so heralded to the public. The man that attempts the management of a difficult surgical case, and all laparotomies are difficult, without a reasonable experience as assistant, is dangerous, and should be so heralded to the public. The specialist that does not have a knowledge of medicine sufficiently broad to estimate symptoms with a fair degree of correctness, and that uses a microscope of a power so high that he sees only a very limited field, is an amateur, and should be so heralded to the public. The man who does not use his microscope to make or confirm diagnoses whenever possible, is an amateur and will always remain an amateur surgeon. I have several young friends that do not subscribe for the Journal of the American Medical Association, and I am afraid they will always re-

main amateurs. The man that does not often think that his work is far from perfect, that is not a severe critic of himself and of his methods, that considers himself as good as the best, is an amateur. I believe that the really competent and able man sometimes, often, experiences the feeling ascribed by Osler to the mystic in his "Alabama Student." "They see the travail of their souls and are not satisfied, and in the bitterness of the thought that they are not better than their fathers are ready with Elijah to lie down and die." Not a comforting sentiment, but it comes with force to the men that are striving for better things: the amateur never has this feeling. Good internists are as scarce as good surgeons, they should command just as good fees, and internal cases are often more difficult, although a fatality does not rest as heavily on the shoulders of the internist, yet the responsibility is the same. The man of any age, that loses a case of pneumonia or typhoid without consultation is just as reprehensible as the man that loses a patient in what should have been a simple and safe surgical operation.

The demand for better service is just as urgent in medicine as in surgery. I believe that the honest, conscientious, painstaking doctor will soon come into his own, be he internist or surgeon.

The remedy for commercialism is fewer and better medical schools, with the immediate and complete elimination of commercial teachers from all schools, a fifth hospital year, fewer and better doctors, less drugging and more teaching, equalization of fees, and publicity. Let Arno Dosch and Norman Barnesby, Lord Murphy, Reed, and others continue their agitation until, the public is taught to "stop, look, and listen." If the medical profession will not purify itself from within, let it be purified from without.

The State Examinations.

The medical profession has no quarrel with any real or so-called school of medicine, it favors no special school, it recognizes no special school but welcomes to its ranks every educated physician, and wishes a full measure of success to every man that practices the healing art. But the medical profession and this society stand for equal tests for all in the basic principles of medicine. No treatment according to any school is possible unless a diagnosis be made, without which the grossest and even criminal errors are unavoidable. On this point there can be no question. Hence the state examination must include all the subjects usually taught in a medical school, except therapeutics and materia medica, which may well be left to the schools. There should be no examination in "Practice" but a searching examination in "Internal and Nervous Diseases." The examination must include the causes, the pathology, and the symptoms of all internal diseases, and all the so-called fundamental branches, all of them, that a diagnosis may be pos-

sible. It is no concern of the state board of medical examiners whether an applicant be a so-called regular, homeopath, eclectic or what not, so long as he is well trained in pathology, pathogenesis, etc. . Clean, competent, honest stimulating competition is welcomed. Let us hope that the time is not far distant when a national board of examiners will take charge of all examinations, and issue all licenses to practice medicine. Perhaps a board representing a group of states would be more practical, as suggested by Mr. Hallet of the Royal College of Surgeons, at the recent conference in Chcago.

The Public and the Physician.

I said that the public pretty thoroughly distrusts the physician and not without some reason. The loud and continuous hammering the profession is receiving because of its commercial tendencies, and because of the large per cent of entirely incompetent men within its ranks in a measure explain this distrust. Only a few days ago one of the foremost scientists in the country said to me "What benefit can come from a consultation, doctors always support each other, the patient is no wiser, consultations are merely a matter of form." This statement was made by an educated observing man. Does it indicate that he has great confidence in the integrity of the profession? Is there any basis for his suspicions?

I often think that the number of quacks in a community is a measure of the manner in which the profession has met its obligations. I recently asked a well known practitioner whether he gave his patients sensible advice, whether he instructed them in medical matters. "Sensible advice, instruction, no. They want treatment and I treat them." This sentiment put into practice is sure to work to the advantage of quacks and quackery. An intelligent community, intelligent in medical matters, is not a good field for quacks. Every physician should become the teacher of his patients. The public must be educated, and doctors must be the teachers, at the bed side, in the consulting room, always telling the truth about medical matters. If every doctor would do something in this line, if only a little, the sum total would be a stunning blow for dishonest and illegal practitioners.

Says Benjamin Moore, in "The Dawn of the Health Age" along these same lines, "The Medical profession sadly requires to have some dignity put back into it, by being made a truly teaching profession. Medicines must be given sometimes, but at the same time if doctors could see their way to give one-tenth the present amount of drugging and ten times the present amount of teaching, it would be better for both the world at large and the self respect of the medical profession." Less drugging and more teaching, is a slogan by which to conjure.

DR. WILEY AND THE OWEN BILL.

You all remember the unworthy effort to force this faithful public servant from his important position. Feeling that by so doing I should reflect the sentiment of this Society, I sent a message to President Taft "That the two thousand members of the Iowa State Medical Society endorse and believe in Dr. Wiley because of the great work he has done and is doing. A very courteous reply came from the White House, but of course under the signature of the President's secretary. But Dr. Wiley has resigned. I have so much confidence in his judgment that I feel that he is working for better things, that he sees better and bigger things in the not far distant future, a National Bureau of Health. About this just a word. I need not dwell on the urgent need for such a bureau, or on the work done by the League of Medical Freedom to prevent its organization, but "who," says Earl Mayo, "are the chief opponents of the establishment of a National Bureau of Health and who oppose all supervision in health and medical matters, state or national." "What other interest," says Mayo, in referring to the patent medicine interest, "has the ability, even if it had the disposition, to raise hundreds of thousands of dollars for a continuous campaign against the proposed National Bureau of Health, all in the guise of medical freedom." "Freedom," says Mayo, "to poison, to debauch, and to slay, and such opposition should bring to Senator Owens the support of every decent citizen." Much has already been done to voice the sentiment of the profession and of the people on these matters, but much remains to be done. A direct and forceful appeal must be made to the broad minded men that represent the state of Iowa at Washington. I should suggest not only that the House of Delegates send a suitable message to Senators Owen, Cummins, and Kenyon, but that every member of this Society communicate with his respective representatives in Washington, asking for early and favorable action on the Owen Bill, known as Calender Bill No. 561. These letters must be written at once. In addition, every member should induce as many influential citizens as possible to write similar letters. The Owen Bill would become a law very soon if the members of the medical profession were half as busy as the League of Medical Freedom. We must not be caught napping, we are responsible for the attitude of Iowa in this matter and now is the time for action.

The Owen Bill has recently been reported favorably by the Senate Committee, not only is this reason for encouragement, but it is reason for additional effort. Everybody must get busy and boost. Write letters, to the Iowa senators and representatives, write many letters, and at once.

A Crying Need and an Opportunity.

We owe much to Rochester and much to the leading surgeons of Chicago and other great cities. They have thought of us, and prepared for us an annual Congress of surgeons, and other like entertainment. We can go to a large city at any time and see noted men at surgical work, always technic, until we forget everything else. What we need most of all and what we want is not operations, not technic, but pathology and diagnoses, medicine and medical clinics. We need and we want careful clinical methods, we want diagnostic methods, we want to refresh and rejuvenate ourselves by again seeing and hearing Pepper, Charcot, Nothnagle, Gerhard, Bramwell, Gowers, Kraft, Ebing, and Dejerine. We must be brought to a higher estimation of things medical. We want to get acquainted with the internists and the neurologists, with Dock, Billings, Edwards, and Sippey; with Patrick, Church, and Hecht. We want to see these giants in action, we want to observe and study their methods. These are the men that can stand on the bridge, that have it in their power to stay the surgical onslaught, and to entice younger men and older men too, back in medicine. Let Chicago arrange a medical clinic for senior students and doctors, three or four hours each week day, let the time and the place be widely heralded, in different hospitals on different days, let the keynote be diagnosis and clinical methods. These clinics would soon be as well known as are the surgical clinics, and they would soon become veritable medical meccas. A Surgical Congress makes for more surgeons, and I hope that it makes for better surgeons. But it is an omnibus, spectacular, opera glass affair. I sometimes fear that it fosters the idea that surgery is so easy, and so profitable, and I hope that it stimulates serious study of surgical problems, I hope that it makes for better diagnostitians, I hope that it makes for better surgical pathologists.

In addition to the daily clinics already mentioned, a Medical Congress conducted much as the Surgical Congress is conducted would stimulate the often waning spirits of the internists, and every general practitioner is an internist. Such a congress would divide honors with the Surgical Congress, or perhaps rank higher as a factor making for progress, and do more good. I would not have this an idle appeal, many many times have I longed for medical clinics. There are more than enough internists in Chicago and St. Louis to accomplish wonders in this direction without undue hardships to anyone.

The surgeons are doing all the shouting, while the internist bewail the lack of appreciation for their work. This is not as it should be, and the remedy is easy. We need diagnostic methods, we must improve ourselves, we must again be taught how to examine patients, how to read, and to correctly estimate. There must be clinics that set

men thinking, that inspire correct methods, the benefits will be immense. Will our appeal be heard by the men that have it in their power to teach us better methods and higher ideals. I hope so. We appeal to the Chicago and St. Louis internists to inaugurate a series of medical clinics and a Medical Congress. They will be successful. Many of you know how attractive the clinics of Nothnagel, Charcot, Mendel, Kraf-Ebing, and others were to medical men. Chicago and St. Louis can duplicate these clinics. Will they heed the call?

The Men of the Hour.

In closing, I should say that the need and the hope of the profession is young men, earnest, well trained young men, men of high ideals, but in this work of ours there is but one test for age. The man that reads, the man that studies, the man that does not let a day pass without an effort to make himself a better doctor, the man that attends his county and state society, the man that frequently visits medical centers, the man that prepares papers for his county and other societies, is a young man, and in him lies the hope of the profession. The man that isolates himself from his co-workers, that works alone, that feels that attendance at medical meetings is time wasted, and that nothing is to be learned at medical centers, is an old man regardless of the date of his birth. The man that is ready to write a paper when invited to do so is a young man. Recently I spent a day with one of the leading surgeons of our sister state to the eastward. Casually, he said that he had in mind twelve subjects on which he wished to read papers. His papers are much sought and always good. That man will never grow old, and what an example he should be to some of our old men that graduated during the first ten years of the present century that are too busy to prepare papers, or that do not regard an invitation to read a paper as a precious compliment calling for their best effort. I know a large number of men that began to age the day they graduated, that have grown older and older ever since, that are now bent and decrepit in medicine, although they have not yet reached the age of forty years. I know many men of sixty-five or seventy years, that are active workers, with most receptive minds, and these men are still young, and we love them for their youth. The need of the hour is men that love medicine for its own sake, that are enthusiastic tireless students, clean men, honest men, men that are brave enough to say "I do not understand your case," men that strive to make a diagnosis rather than blindly prescribe, men that are painstaking, progressive, receptive, sympathetic, big hearted, warm blooded men, God fearing men, I love God fearing men, men that never forget that all their training, all their effort has for its object only the best interests of the patient, to which every other consideration is secondary. These are

the young men so sorely needed, they will never grow old; and "men" all through this paper includes men and women. The grandest young man in Iowa today, we all love him, is Edward Hornibrook of Cherokee.

I wish to say that I believe that there are hundreds and hundreds of men practicing in Iowa, the larger per cent of them country doctors, that in a progressive spirit and in devotion to duty excell their city confreres. There are in Iowa today hundreds and hundreds of country doctors that are fully competent, and that merit the sympathy and warm affection so freely given to that "good old country doctor."

My faith in the future of the profession is unbounded, the future is bright with promise. We shall weather all our storms, commercialism will disappear, the public will be more intelligent and responsive, hospitals will bar their doors to the unworthy, the commercial schools will be throttled, and the material rewards will be sufficient to attract the very best men. The profession will continue worthy of its great inheritance, of the inheritance left it by Lister, McDowell, Laennec, Jenner, Hunter, Harvey, Koch, Pasteur, and Ross, a few of the immortals that grace our guild. It will be a better and a purer profession, a fit profession for your son and for mine.

REALIZATION.

When winter brought its weary round
  Of fires and drifting snow
He yearned for summer's dreamy days
  And hammocks swinging low.
But now the lovely June is here
  With birds and blossoms gay,
So he proceeds to cut the grass, oil the automobile, freeze ice cream, paint screens, pull weeds, sprinkle the yard, plant vines, and in sundry and divers idle pleasures of a similar innocuous character contrives
  To dream the hours away!

—*June Lippincott's.*

THE ORIGINAL.

A reporter was interviewing Thomas A. Edison. "And you, sir," he said to the inventor, "made the first talking machine?"

"No," Mr. Edison replied; "the first one was made long before my time—out of a rib."

—*National Monthly.*

Original Articles.

PNEUMONIA IN CHILDREN.*

THOS. P. BOND, M. D., DES MOINES, IOWA.

In taking up this subject, it has been my aim to make my paper as practical as possible, touching briefly on the theoretical aspects and those points of common knowledge with which every medical student is familiar by the time he reaches his junior year. As we all know regular lobar pneumonia in *young* children is comparatively rare and the disease in this class of cases usually takes the form of a capillary bronchitis or broncho pneumonia; hence, we shall consider capillary bronchitis and broncho pneumonia entirely separate from lobar penumonia as seen in older children. In the former, the finer bronchi are involved and in the majority of cases the disease spreads to the lung tissues proper resulting in a broncho pneumonia, or as sometimes less accurately described as "lobular penumonia." The lung is invaded with numerous nodules, which are usually found posteriorly and in the lower lobes. These rapidly spread and increase in size, causing larger portions to become consolidated.

Pathology.—According to Aufrecht—"Capillary bronchitis presents an enormous dilatation of the corresponding blood vessels. The lumen of the bronchiole is diminished by the greatly swollen mucosa and occluded by purulent and occasionally sanguinous exudate. The occlusion of the bronchioles leads to atelectasis of the alveolar areas, which formerly was regarded as the chief cause of the development of the broncho pneumonic areas. The pneumonic areas do not develop as the result of direct extension of the inflammation from the bronchioles to the alveoli, but by spreading of the inflammation from the walls of the bronchioles and through the walls themselves to the surrounding tissue, which is markedly infiltrated with lymphocytes.

An inflammatory oedema now extends from the septa of the alveoli to the neighboring alveoli leading to colonization of the bacteria in this region, to casting off of alveolar epithelium, and to distention of the alveoli with white blood corpuscles. A small quantity of fibrin is also found in the alveoli but never in the same amount as in croupous pneumonia. Frequently also red corpuscles are found in varying numbers. In the beginning, broncho pneumonia produces areas of peribronchitis varying from the size of the head of a pin to that of a small pea, which surround the pus-distended bronchioles between which lie areas that are still intact and that still contain air. These areas gradually increase in size and become more numerous. Becoming confluent they may involve an entire lobe. As a rule, the broncho pneumonic areas are dark blue in color and tough, later becoming grayish yellow in appearance with prominence of the infiltrated lobuli. On pressure thick pus oozes from the bronchioles, which are partly dilated. In addition to the pneumonic areas, as a result of the shutting off of the air, larger and smaller areas of atelectasis are to be found, especially in the dependent portions of the lungs."

*Read before Polk County Medical Society, April 30, 1912.

Etiology.—As a rule the etiology is the same as that of simple bronchitis, the disease occurring in connection with inflammatory conditions of the upper air passages, and often in certain acute infectious diseases as measles, pertussis, influenza and diphtheria, while it is also frequently found in severe intestinal disturbances.

Capillary bronchitis and broncho pneumonia are pre-eminently diseases of early life, becoming less frequent after the fourth year. The largest number of cases being seen between the ages of six months and two years. It is probably always of an infectious character and the bacteria of the primary disease is frequently found in the bronchioles or alveoli, sometimes in pure culture and sometimes as a mixed infection.

General Course of the Disease.—The onset of the disease is announced by fever, severe coughing and dyspnoea, respiration is rapid and labored, the cry is short and suppressed and the pulse rapid and small. The lack of oxygen soon causes cyanosis, noticeable first at lips and finger nails— anorexia and weakness rapidly develop. The face is pale and anxious and the patient very restless.

Physical examination shows medium and fine subcrepitant rales specially in the lower and posterior portions of the lungs. Percussion is frequently negative *anteriorly* but careful posterior percussion will locate areas of consolidation. Personally I believe that a failure to spend the necessary time to make a very careful and thorough physical examination is responsible for a large percentage of the errors in diagnosis in the earlier stages of these diseases.

Secondary broncho penumonia is frequent enough to call for more than passing notice. It is the most frequent cause of death in both pertussis and measles. In the former it is often more dangerous than in measles, however, if it appears in measles before the exanthem it is often rapidly fatal. In epidemic grippe it is quite common and in scarlet fever, while not so frequently occurring, runs a severe course and is apt to result in empyema.

One of the most frequent complications is otitis media, (often unnoticed in the beginning) which frequently leads to perforation. One authority states that otitis occurred in 50 per cent of his cases.

Prognosis is always doubtful and the younger the child the more grave it becomes. In cases under one year of age, the mortality is very high, some stating over 50 per cent. In cases of poorly nourished rachitic children, or where a gastro intestinal disturbance is present, specially if the hygenic surroundings and nursing are bad, the prognosis is decidedly more unfavorable. In general, we might say that the prognosis depended largely on the degree of dyspnoea, the amount of cyanosis and the quality of the pulse.

The diagnosis of capillary bronchitis is made from the medium and

fine rales without consolidation, while that of broncho pneumonia is made from the appearance of smaller or larger areas of consolidation to bronchial breathing and circumscribed metallic rales. In the early stages it is often impossible to differentiate but this can usually be done in a reasonable length of time.

Treatment.—As in all other cases of disease affecting the lungs, sunshine and fresh air are of vital importance and the sick room should, if possible, be selected with these in mind and provision made not only for frequently changing the air, but to keep it moist, either by a regular croup kettle or some home made device. The child's nutrition should be given careful supervision, particularly if there has been any tendency to gastro-intestinal disturbance. Good digestion is of greater value than expectorants. Baths, chest compress, moistening of the air, inhalation of oxygen and in some cases some stimulation are among the modern methods of treatment. Of course, the age and general condition of the child should govern the temperature of the chest compress and bath. As a rule, this will be all that is necessary to control the temperature. There may be some who still cling to antipyretics, but, personally, I do not approve of them. If rales are numerous expectoration should be vigorously stimulated. In some cases a warm mustard pack will cause a marked hyperaemia of the surface of the body which in turn seems to deplete the lungs. For this, about one tablespoonful of mustard flour is used to one pint of warm water (104°) and stirred for ten to fifteen minutes; a cloth is dipped in this and well wrung out and the patient wrapped from the neck to the feet and remains from ten to thirty minutes. After this he is bathed and put into an ordinary warm moist pack for one-half to two hours to maintain the hyperaemia. If cold packs or baths are used a stimulant should always precede them. However, by this I do not wish it understood that I refer to alcoholic stimulation. Caffeine and digitalis are the best.

Croupous or Lobar Pneumonia.—The history of lobar pneumonia is interesting as it is a disease that has been known since the earliest times, not only to the medical profession, but to the laity. Norris, in his historical sketch, says, "It is prominently mentioned and discussed by Hippocrates, although at this time there was much confusion and no differentiation between pneumonia, pleuritis and other acute thoracic diseases.

Etiology.—It is an acute infectious disease caused by the diplococcus pneumoniae, which is found in large numbers in the affected portions of the lung as well as in the sputum of pneumonia patients. While we now generally recognize pneumonia as an infectious disease, we should not wholly ignore the predisposing causes, as they play a very important part. Duerck has shown that for the development of

pneumonia in animals a definite traumatism is necessary. Eg. the inhalation of dust, the so-called "colds," injury to the thorax, season of the year, age, sex, etc. This same investigator found pneumococci in twelve out of thirteen healthy children and more often in boys than girls. The disease is not common before the third to sixth month, is quite frequent during the second year, and is found in the greatest number of cases from the second to seventh year of age.

Toxic Products.—Comparatively little is known of the metabolic products of the pneumococcus. Musser says, "The toxic substance is an intracellular toxin; that is, it does not appear in soluble form in fluid media in which the organism is grown, but is intimately bound to the cell body. The freeing of the toxin in the living body is supposed to be due to the disintegration of the living cells. While the possibility of the production of a soluble toxin in the living body cannot be denied, we as yet have no actual proof that such is the case."

The Pathology is the same as in the adult and will not be considered.

General Clinical Picture.—In older children the onset is the same as in adults; i. e., sudden, with chill and pain in the side. In younger children there is often a history of cough, lassitude and general discomfort for several days before the actual onset of the disease, when the patient becomes very ill and wants to go to bed. The temperature is high, pulse tense and rapid, respiration rapid, and pain is complained of either in side or upper abdomen. Cough is slight or absent, there is no expectoration and physical examination is negative. This not infrequently leads to errors in diagnosis until the third to the fifth day when the usual physical symptoms appear and perhaps at about the same time the appearance of a herpes labialis first leads to a more careful and thorough examination of the lungs. About the same time what we might term external symptoms become more apparent; viz., the respiration is more rapid, with dyspnoea and dilatation of the nostrils. Expiration is suppressed and of grunting or moaning character. The cough is short and suppressed and is often followed by crying because of the pain which it produces. The high temperature with the small amount of nourishment taken results in a rapid loss of strength and the facial expression is pinched and anxious. About this time the toxic symptoms become more pronounced and a marked apathy, somnolence, delirium and alarming weakness develop and continue until the longed for crisis occurs, which is usually from seven to nine days after the onset. If the disease does not come to a crisis, either from a fresh infection of another lobe or for any other reason the condition constantly becomes more serious and death occurs usually during the second week.

Prognosis.—In an otherwise healthy child the prognosis in this dis-

ease is probably better than in any other severe disease of childhood. The mortality is only from three to five per cent and is chiefly in the cases occurring during the first and second years of life. Rosenow and Wolf in their study of the opsonic index both found that where the index had a tendency to rise as the crisis approached the prognosis was always good, while it always remained low in fatal cases. On the whole the prognosis is much better than in broncho pneumonia. A very high temperature with severe dyspnoea, crisis delayed beyond the ninth to eleventh day make the prognosis grave.

Treatment.—In previously healthy children, the majority of cases of croupous pneumonia will recover under any treatment provided it is not directly injurious. Copious blood letting, severe irritation of the skin, and powerful drugs belong to the past. Provision must be made for an airy room and plenty of bedding if the weather is cold. As the mouth is fairly swarming with bacteria, special attention should be given to the throat, teeth and upper air passages. The diet is of great importance and should be of such a character as to be highly nutritious and yet not tax the powers of digestion. For the control of the temperature hydrotherapy is the ideal treatment and I think the best results I have ever had in the treatment of this disease either in robust children or adults has been the cold pack (70°) to the entire chest changed every hour and fresh air, the latter obtained by having the windows wide open regardless of the outside temperature. As soon as the temperature shows a tendency to drop, or in other words as soon as the crisis is well begun, the wet pack is no longer changed, but is allowed to become dry and then a heavy cotton jacket is substituted and kept on until all signs of consolidation have disappeared, when it is gradually removed by picking out some of the cotton each day. I believe that acute pyretics should never be used in this disease. The patient's heart already has enough to contend with, so why give a drug to still further depress it? If heart stimulation is necessary, digitalis, caffiene and camphor are among the best drugs to use. After the crisis, absolute rest and quiet should be maintained until all symptoms of consolidation have disappeared during the convalescence the anaemia and weakness make the administration of iron, quinine and malt preparations desirable.

THE NON-SURGICAL TREATMENT OF CROSSED EYES IN CHILDREN.

RALPH H. PARKER, M. D., DES MOINES, IOWA.

The management of cases of crossed eyes in children requires tact, patience and perseverance on the part of the physician and the hearty co-operation of the child and its parents. The advice so often given to these cases, "To wait until the child is older and then have the eyes straightened by an operation," is not in line with the ophthalmic teaching of today.

Convergent strabismus (squint) usually begins early in life. It becomes noticeable when the child begins to fix near objects. The mother usually ascribes it to a fall, or scare or some particular happening from which the squinting dates. The large majority of children squint because they are far sighted which is usually combined with astigmatism. Squint comes on periodically at first and later, if not treated, becomes permanent. Both eyes do not squint at the same time, one fixes the object and the other converges. The eyes may alternate in fixing the object, the squint being first in one eye and then the other.

Children with strabismus do not complain of double vision as in cases of paralytic squint. They learn early to suppress the object seen by the squinting eye, much the same as the microscopist who becomes unconscious of the excursions of the left eye while working at the microscope with his right.

It might be an aid to our understanding of strabismus to review the conditions which cause it. The theory of Donders, which is quite generally accepted, that convergent squint is due to a disturbed relation between convergence and accommodation, is logical. The same nerve impulse is sent to the muscle of accommodation and the muscles of convergence. An impulse which causes the normal eye to accommodate to a fixed point also causes the eye to converge to the same point. In the first act of vision an impulse is sent to the internal recti and the muscle of accommodation over the motoroculi nerve. The impulse sent to the muscles of accommodation and convergence always bear a definite relation to each other. The stronger this impulse the stronger the convergence and the accommodation. If the eye is far sighted a very strong impulse is sent to the muscle of accommodation to get the lens in proper shape for near vision. This same impulse is sent to the internal recti to pull the eye in for convergence for near vision, but being so much stronger than necessary the eye converges too far and squints. This is probably the best explanation offered for squint. It does occur in far sighted children and the strong impulse necessary to get the proper accommodation gives too much convergence. What usually does happen is this: Both eyes do not over converge, but one will fix

the object and the other will converge in excess or squint. These eyes may appear normal if kept at distant vision, but as soon as near vision is attempted the squint will appear.

Treatment.—Spectacles, cycloplegics, the monocular occlusion pad and the sterescope are all made use of either singly or combined in the non-operative treatment of squint. It is understood in advising the use of spectacles that the refraction is to be done by the aid of the retinoscope and ophthalmoscope while the eye is under atropine and by a competent eye doctor. The accurate refraction and wearing of properly fitted spectacles takes first place in the plan of treatment. Cycloplegics are used in the early care of the case and in arriving at a proper refraction. The occlusion pad assists in over-coming the squint habit.

The proper refraction of these children is the most important part of the treatment. The retina reaches its full development in early youth and it is essential that it be brought into active exercise as soon as possible by properly focusing lenses, thereby assuring its highest possible development. Many of the patients can be taught to wear spectacles at three years of age. The refraction should be done under a cycloplegic and by retinoscopy. The full correction should be given. Patience will be required in teaching the child to wear the spectacles as we are dealing with children that are leading rough and active lives and the frames will need frequent adjusting to keep the lenses in proper position before the eyes. The success of this plan of treatment depends upon an early beginning. After the child has been squinting for years and the eye has become partially or totally blind from disuse, spectacles have less value as then we have not a refractive error alone but also a retina incapable of receiving impressions.

These children will not squint if kept at distant vision, so this fact is made use of in the treatment. Distant vision is maintained by the use of atropine, one to ten drops of a one-fourth per cent solution in each eye twice daily is usually sufficient. This plan of treatment may be followed until the child is refracted.

The use of the occlusion pad is valuable in the non-operative treatment of squint. This pad should be placed over the good eye two to four hours each day thus requiring the child to use the squinting eye, i. e., he exercises it, which retains the function of the retina. It is necessary that the occlusion pad is properly fitted over the good eye so that it takes no part in vision. The spectacles should be worn while the occlusion pad is used.

The use of sterescopic pictures has long been in vogue and many clever plans for their employment have been devised, but as the various schemes are all more or less complicated and as the exercises soon grow monotonous to the child, they are soon abandoned. A simpler and fully

as effective muscle exercise test is to have the child hold the head in one position while it follows with its eyes the movements of a pencil held in the hands of the parent, which is moved up and down, right and left, thus forcing all the recti muscles into active use. This should be done as often each day as possible.

The following cases will serve to emphasize some of the points taken up with this paper.

Fig. 1.—(Case I). E. J., 8 years old, alternating convergent strabismus.

Case I.

E. J., age 8 years.

Vision right eye, 20-80.

Vision left eye, 20-80.

Alternating convergent strabismus.

Right eye, 6 diopters far sight, combined with 2½ diopters far sight astigmatism axis 90°.

Left eye. Same as right.

With glasses; vision right eye, 20-40; left eye, 20-40. Squint disappeared upon wearing glasses to re-appear upon attempting close work with them off.

Fig. 2.—(Case I.). Same as Fig. 1. The squint disappears when wearing the glasses which are corrected for six diopters of far sight and 2½ diopters of far sight astigmatism axis 90 to reappear as soon as glasses are discontinued.

CASE II.

T. A., age 6 years.

This child had a permanent squint of right eye. He was not of sufficient intelligence to get the visual acuity.

Refracted by retinoscope while under a cycloplegic.

Right eye showed 6 diopters far sight combined with 1 diopter far sight astigmatism axis 90°.

Left eye. 4½ diopters far sight, combined with 1.5 diopters astigmatism axis 90°. The full correction was given as found.

Fig. 3.—(Case II). T. A., 6 years of age, right or squinting eye had 40 per cent more far sight than left eye. Each eye gave more than 4½ diopters of Hyperopia.

CASE III.

M. K., age 8 years.

Alternating squint.

Right eye. 3 diopters far sight combined with 1.5 diopters far sight astigmatism axis 60°.

Left eye. 3 diopters far sight, combined with 1.5 diopters far sight astigmatism axis 120°.

These glasses were given for constant use. This patient was advised by her physician, when three years of age, to do nothing with the eyes until older, when she might need an operation upon them. The eyes straightened after wearing the above lenses.

CONCLUSION.

1. The end hoped for in these cases is that the child may obtain binocular vision. This can only be accomplished by the most painstaking care and persistence on the part of the physician aided by the faithful co-operation of the parents.

2. These children should be under management as soon as the squint develops. The more delay the less probability of perfect results.

3. Atropine should be used to prevent the patient from using the eyes for close objects.

4. The refraction must be accurately done under atropine and the correction constantly worn.

5. The muscle exercises should be persistently used for a long time.

6. The few cases that are not cured by the treatment as outlined may need a tenatomy or advancement.

TREATMENT OF NORMAL PUERPERIUM.*

M. L. TURNER, M. D., DES MOINES, IOWA.

I do not expect in presentation of this paper on "Treatment of Normal Puerperium" to present anything new and very little that is at variance with the accepted treatment of many of our obstetricians. The paper will be very short and will give ample time for a thorough discussion from members of the profession much better qualified to discuss the subject than I, and if in the discussion something new may be said or something old may be presented in a new light, I will feel the paper has served its purpose.

Normal puerperium presupposes a normal birth. No fast line can be drawn between a normal and pathological confinement. At most births, and I think we could safely say with every primipara, there is more or less injury to the parturient canal and especially to the vaginal outlet. I believe then that if the patient is otherwise healthy, that a puerperium may be considered normal that does not call for surgical interference after the third stage of labor is completed.

To read some of our text books and articles in Medical Journals we are almost led to believe that there are few cases of labor that are normal and that only a few would survive the ordeal without the assistance of an expert obstetrician: but the facts are that meddlesome midwifery in the past and before the time of antisepsis has probably caused more deaths among our civilized people than the neglect of cases that needed assistance.

The puerperium begins immediately at the close of the third stage of labor and in normal cases the uterus is firmly contracted but should be watched to determine if it remains so. The use of a folded towel placed over the fundus under a tightly drawn bandage for a compress is uncalled for. If there is enough evidence of an abnormal condition to warrant this procedure there is need of the physician's constant attention and he should not leave the patient until he is satisfied that the uterus is firmly contracted.

The changes which take place the first two weeks following labor are physiological. Some authors state, however, that under no other circumstances does such marked and rapid tissue metabolism take place without a departure from a condition of health. The involution of the uterus following normal labor is quite rapid and after one week or ten days can not be felt above the symphysis.

The vulva should be thoroughly washed with some antiseptic preparation, 1 to 2,000 or 4,000 bi-chloride preferable. This washing of the vulva should be repeated after each dressing. It is not necessary

*Read before the Polk County Medical Society May 24, 1912.

to irrigate the parts each time the dressings are changed but they should be washed with pledgets of cotton or gauze dipped in antiseptic solution. The attendant, if not a nurse who has been properly trained, should be instructed to wash from above downward to avoid any contamination from the rectum. The dressings should be changed as often as necessary owing to the amount of lochia. The dressing best suited for the absorption of the lochia is made of cotton wrapped in gauze. In private practice, however, this is not always forthcoming and we are often compelled to resort to other dressings; these are usually composed of cast off garments, sheets, pillow cases and other absorbent materials; and should have been thoroughly washed, and then baked in an oven just before using. This can be done by wrapping them in several thicknesses of newspaper and placing in an oven with a slow fire. The expectant mother should be instructed how to prepare these as well as the sheets and gowns that are to be used about the bed.

No binder is necessary. It serves no purpose in preserving the woman's form and is a most uncomfortable appliance in most cases. In fact, I believe that it is injurious in most cases and retards the return of the abdominal muscles to their normal condition. Immediately following labor the abdominal muscles are soft and flabby and should be used in order to stimulate contraction. The time when these muscles are most active in contraction after they have been extended for a period of time is immediately following labor when nature intended that they should be so. An abdominal binder prevents the use of these muscles and the return to their normal condition is much slower than it would if left free. If the patient is inclined to be stout, or if there has been a very marked distention of the abdominal muscles, the folding in of these soft flabby muscles in order to place the binder makes pressure on the uterus and by some is thought to produce retroversion.

As soon as the mother has been washed and cared for and returned to her room, if in the hospital, the nipples should be washed with sterile water and the babe placed to the breast. The nursing of the child causes a firmer contraction of the uterus and I find that most babes following normal labor will nurse better soon after birth than they do if not allowed to nurse until six hours afterwards. I have seen babes with their thumb or fingers in the mouth nursing hard five minutes after birth and would keep it up for an hour that could hardly be induced to take the breast after six hours. I know that this is at variance with much of the teachings of today but I believe that it is as nature intended.

The primary object in the treatment is to keep the patient as comfortable as possible. A light airy room is preferable to the darkened room. No darkened room can be cheerful. Sunlight is preferable to

shadows. It is not necessary that the light shines directly in the face and the bed can be so arranged as to avoid this. Few visitors should be allowed and these confined to relatives and few close friends. No person should be allowed to visit a patient through idle curiosity. The excluding of visitors is not alone for the purpose of giving the patient rest but because of the possibility of carrying infection. In the city where persons go to and from the home or hospital on the street cars they may come in contact with scarlet fever or some other pathogenic germs which may be carried to the patient.

The diet should be the same as that taken before confinement. Do not confine her to toast and baked potatoes. If the mother has been used to a fat and proteid diet during her pregnancy, she should continue this diet during puerperium. I have seen digestive disturbances caused when changing from a home to a hospital diet. I believe, too, that some of our colicky babies are made so by the change of the diet of the mother. If the child in utero has been fed upon proteids and fats, the change of the diet of the mother from this form to that of a strict carbohydrate diet produces such change in the milk as to affect the child. So that the only change in the mother's diet should probably be a little less in quantity of what she has been taking. It is presumed here, of course, that what she has been taking has been the food necessary to keep her in a healthy condition.

The bladder should be emptied within six hours after confinement providing this can be done without the use of the catheter, and it can usually be done if the patient is allowed to sit on the commode or jar instead of using the bed pan. I do not believe that the bed pan is indicated in the treatment of normal puerperium except when irrigating the vulva. The patient should be allowed to sit on the commode or jar beside the bed whenever there is an evacuation of the bowel or in urinating. If this is done less physic will be required, the lochia will flow more freely and especially is the latter true if there are small clots. The commode or jar should be thoroughly cleansed before using. Where the toilet is only a few steps from the bed, as is often the case in the hospital, I permit them to use the toilet instead of the jar after the first few days. If the patient is allowed to do this she will not have that tingling of feet and dizzy head that comes to her the first few times she places her feet upon the floor after ten days or two weeks in a horizontal position, and I do not believe that it has a tendency to cause displacement of the uterus.

No douche is necessary. The lochia of the uterus and vagina is sterile and does not become pathogenic until it has passed the vulval opening. The vulva is always considered germ laden and it is impossible to pass a sterile tube through the germ laden vulva without carry-

ing pathogenic germs with it, unless under the strictest antisepsis which can only be carried out in a hospital. So that the use of the douche is unnecessary unless the case becomes pathological.

After pains can not be excluded from normal puerperium, especially in the multipera. Dram doses of ergot may be given every two or three hours or phenacitine in small doses from three to eight grains. Opiates should be avoided if possible, because of the tendency to constipate.

Since preparing some of the notes for this paper I received the April number of the Indiana Medical Journal which contained a prize essay by William Brady of Elmira, New York on the subject "Treatment of the Mother after Childbirth without an Assistant." This was copied from the New York Medical Journal. It is very short and I desire to present it here.

"Every household, even the veriest hovel, has an oven, some clean rags and a yard or two of old sheeting or toweling; so there is never a good excuse for applying unsterilized vulvar pads in an emergency case of labor. Every mother dreads "blood poisoning" and fever; instruct her how unwashed fingers, touching her pads, her vulva, or her breasts, may induce the complication she dreads and you may rest assured there will be no puerperal infection.

Without an assistant or with an assistant, it is the duty of the obstetrician to remain at the woman's side at least twenty minutes after the birth of the placenta, with a hand resting on the fundus. As to the use of ergot there are three points one should bear in mind. First, that a physiologically active and recently made supply must be carried; second, that the effect of ergot continues only a half hour, semi-hourly doses being required if the effect is to be maintained. Third, that it acts in fifteen minutes by mouth. In a normal confinement, ergot is certainly unnecessary and should not be given as a routine practice. If, for any reason, it is indicated during the second stage, it should be administered without fear of the bugaboo of hour glass contraction. This condition, like that of "adherent placenta," I have never observed in a fairly active practice in country, city and hospital service. One who has mastered the technique of Crede's method of delivering the placenta will find it difficult to credit the old wives' tales of afterbirths 'growed fast to the spine!'

Folded in a sterile towel I carry an emergency kit of sterilized instruments, scissors, scalpel, hemostats, needles, sutures. With this at hand it is a simple matter to cut the cord and dispose of the infant; also, if need be, to repair a lacerated perineum. In a primapara with a rigid perineum, or where the fetal head is large, or the occiput posterior, the preliminary placing of perineal sutures is a harmless and

satisfactory measure; it gives better coaptation than is possible otherwise and is much easier than the post partum suture.

No douche, no enema, no breast pump, no massage, no binder is a good rule to follow in all normal cases. Nature's germicide—the lochia—surpasses anything medicine can supply. Most breast abscesses are the result of pernicious interference by ignorant or uncleanly persons. A woman's figure is not preserved by wrapping about her a wrinkled, rolled up, hot, ill fitting, unhygenic "binder;" the binder binds only in imagination, unless an insertion of elastic webbing is used.

When the patient begins to complain of backache, strap the sacroiliac joints with adhesive plaster strips across from spine to spine of ilium.

When she fails to urinate in twelve hours, set her up on a chamber pot—not a bed pan—and do not resort to the catheter. Most women are still good Indians; they do not drop dead when allowed to sit on a chamber pot.

Do not permit the temperature to be taken unless the patient is obviously ill.

When the lacteal secretion begins, support the breasts for a few days, if painful, with a binder or bandage. Repeat the warning: "Hands off." See that the baby is put to the breast every four hours from birth and every two hours after the milk appears.

On the third night a purge should be given—phenolphthalein, five to ten grains, well masticated, and followed in a half hour by some fruit; or jalap, five to ten grains; or caster oil, one ounce, in milk or in emulsion. For the stool, too, the patient should be permitted to sit on a commode if she so desires."

JOHN'S WHEREABOUTS.

A San Francisco woman, whose husband had been dead some years, went to a medium, who produced to her satisfaction the spirit of her dead husband.

"My dear John," said the widow to the spirit, "are you happy now?"

"I am very happy," John replied.

"Happier than you were on earth with me?" she asked.

"Yes," was the answer. "I am far happier now than I was on earth with you."

"Tell me, John, what is it like in heaven?"

"Heaven!" John replied, "I'm not in Heaven."

—*National Monthly.*

HEMORRHAGIC DISEASES OF THE NEW-BORN.*

LAWRENCE E. KELLY, M. D., DES MOINES, IOWA.

* * * Classifications of hemorrhages occurring during the first few days of life have been made upon the apparent origin of the bleeding and upon the etiological factors causing the hemorrhage. The least confusing classification is given by Schloss and Comiskey, who divide all hemorrhages of the new-born into (1) traumatic, (2) accidental, and (3) spontaneous. Traumatic hemorrhages are due to injuries received during labor or following some operative procedure. Accidental hemorrhages are of two varieties: first, bleeding due to faulty ligation of the cord, and second, the slight vaginal hemorrhage which occasionally occurs without bleeding from other sources. Spontaneous hemorrhage may arise from any tissue or organ of the body, and may be divided for convenience into umbilical, purpuric and sero-mucus hemorrhages. Umbilical hemorrhages of the spontaneous variety arises either from the lumen of the vessels before or after separation of the cord, or oozes from the whole cord structure or site of its detachment. Purpuric hemorrhages may be single or multiple, and are most often found over pressure points. Sero-mucus hemorrhages may be from any serous surface or the mucous lining of the air passages and gastro-intestinal tract. The most frequent variety is melena, which is often considered by itself. It is subdivided into melena symptomatica, in which the hemorrhage is a symptom of an obvious disease; melena spura, in which the blood vomited and passed in the stools is from sources outside the gastro-intestinal tract; and melena idiopathica, in which there is no apparent cause for the bleeding. * * *

Etiology.

(1) Mechanical factors: trauma during delivery causing cerebral hemorrhage, rupture of mesenteric vessels and thrombosis, with subsequent emboli, and operative procedures after delivery.

(2) Heredity was considered by many of the early writers as an important cause of severe hemorrhage in the new-born, and "Hemophilia Neonatorum" was used as a generic term for this whole group of diseases. Later statistics, however, show that hemophilia is rarely manifest in the new-born. Larabee was able to collect only thirty-seven cases from the literature in which hemophilia was the probable factor. True, hemophilia neonatorum is therefore extremely rare, and should only be accepted as such when there is a very distinct history of the disease in the family, or when the child recovers from the initial hemorrhage and in after life remains a bleeder.

(3) Infections have for a long time been recognized as an important factor. From the large literature on this point there is considerable evidence, both experimental and clinical, to show that bacterial infection may be the cause of hemorrhage. However, no spe-

*Extract from paper read before the Iowa State Medical Society, Burlington, Iowa, May 9, 1912.

cific organism is responsible for all hemorrhages. The bacterial investigations show the presence of many cocci and bacilli, either in pure or mixed cultures, in the body post-mortem. From the evidence at hand it is apparent that a certain number of cases are due to infections, either local or general, Buhl's and Winkle's disease usually considered in this group are of infective origin.

(4) Syphilis as a factor has been over-estimated here, as in other diseases. However, most writers agree that congenital syphilis is a pre-disposing cause to hemorrhage in a small number of the cases,—two to six per cent, according to Holt.

(5) Ulcerations along the entire gastro-intestinal tract of unknown cause, are reported as responsible for some cases of melena.

(6) Vascular and blood changes have received particular attention by Schloss and Comniskey. They point out that the immediate cause of hemorrhage is probably some vascular lesion, and the persistence of the bleeding is due to a defect in the clot formation. The coagulation time of the blood may be normal, delayed or absent. When clotting does take place, it is defective, that is, it does not form a firm enough clot to arrest hemorrhage.

(7) Intoxications as described by Graham in a recent article are undoubtedly factors. Agents of unknown composition, as toxines of eclampsia and certain forms of septicemia, and known chemicals, especially chloroform, are capable of producing hemorrhage in the newborn. Graham's experimental production of hemorrhages in the newborn animals, by chloroform anaesthesia administered to the mother, are interesting at this time because of the growing unpopularity of chloroform in obstetric practice.

We then have a variety of factors capable of producing a similar clinical picture. The pathology of these hemorrhagic diseases varies with the cause and source of the bleeding.

Symptoms.

Hemorrhage usually occurs on the second or third day of life, occasionally within a few hours, and rarely after the tenth day. Cases have been reported as late as the nineteenth and twentieth days. The time of onset is determined to a certain extent by the origin of the bleeding. Gastro-intestinal hemorrhage occurs most often on second to fifth day, and umbilical on fifth to seventh day.

The most striking symptoms are hemorrhage and acute anaemia. The bleeding may be into the stomach and vomited, into bowels and passed as black, tarry stools, from the umbilicus, from any point under the skin, and in fact, from any organ or tissue of the body.

Premonitory symptoms often are present in internal hemorrhage. The child becomes restless, cries, and refuses to nurse. Abdominal pain may be apparent. The skin becomes pale and cool, the pulse and respiration rapid, and the temperature, at first elevated, drops to subnormal.

The course and extent of these hemorrhages vary. The bleeding may be severe and cease, and the child recovers. Death may occur within two hours, almost before a diagnosis is possible. Again, the bleeding may continue over a number of days before resulting fatally.

The diagnosis is usually self-evident. When the bleeding is not visible and the above described premonitory symptoms are present, a stool should be obtained and examined carefully for blood.

Differential diagnosis of the various forms of hemorrhage are to

be made chiefly on the history and source of bleeding, and the causative factor thus determined.

The mortality of the hemorrhage diseases of the new-born has been estimated as ranging from 35 to 87 per cent. Judging from recent reports, the prognosis is much improved when human blood, or its derivatives, is used in treating these cases.

Treatment.

The indications for treatment are hemorrhage, acute anaemia, and in some cases infection. The only treatment that fulfills these indications is the *transfusion or injection of human blood.* * * *

(1) Traumatic hemorrhages should be cared for along the line of general treatment for bleeding.

(2) In accidental bleeding the cord should be re-ligated.

(3) As soon as hemorrhage of the spontaneous variety takes place, 10 c. c. of blood should be withdrawn from the veins of the arm of one of the parents and injected immediately into the subcutaneous tissue of the child's back. This dose should be repeated every three or four hours until bleeding stops. If there is a reasonable suspicion that the child is syphilitic, inunctions of mercury should be at once instituted.

In severe cases that do not respond to injections, a transfusion should be attempted. If the case is in the hands of one familiar with blood-vessel surgery, of course an immediate transfusion is the best form of treatment, as the child is at once relieved of the anaemia; and if infection is present, this also is quickly overcome by the antibodies of the transfused blood.

GUNSHOT WOUND OF PREGNANT UTERUS.

A. W. Tucker, Shanghai, China (Journal A. M. A., June 1), reports the case of a Chinese woman, aged 26, nine months pregnant, who was shot by a robber in the abdomen. The wound of entrance was about three inches above and to the left of the umbilicus. There was no wound of exit. On opening the abdomen it was found that the bullet had penetrated the upper part of the uterus and cesarean section delivered the living child. The bullet, which was a half inch in diameter and of soft lead, had entered its back over the left scapula and had lodged under the skin near the spine. The mother did well until the second day after the operation, when she suddenly died, probably from an internal hemorrhage. No post-mortem was permitted. The child did well and was taken home the fourth day.

SARAH'S SQUANDERINGS.

In Concord, New Hampshire, they tell of an old chap who made his wife keep a cash account. Each week he would go over it, growling and grumbling. On one such occasion he delivered himself of the following:

"Look here, Sarah, mustard plasters, fifty cents; three teeth extracted, two dollars! There's two dollars and a half in one week spent for your own private pleasure. Do you think I am made of money?"

—*June Lippincott's.*

MICRO-ORGANISMS IN THE URINE.

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When the urine contains bacteria before it leaves the bladder, it develops a condition, which we call bacteriuria. It was first described by W. Roberts in 1881—vide Brit. Med. Journal, 1881. Freshly voided, normal urine does not contain any micro-organisms, subsequently they may rapidly develop, but this condition we cannot call bacteriuria. We can even protect the urine from developing of bacteria in it by adding 1—2 drops of 1 formalin and by doing so, we always will have, even for three or four days clear, not affected urine specimen and there will be made no mistake in determining, if there are bacteria before or after the urine left the bladder.

The appearance of urine charged with bacteria is peculiar and distinctive. The urine is slightly turbid, and when agitated in a urine glass by stirring it with a rod, a wavy sheen is produced, which quickly disappears as the movement set up in the urine ceases. The bacteria do not subside when the urine is allowed to stand and consequently it usually remains turbid until decomposition sets in. No change is produced in the appearance of the urine by passing it through ordinary filter paper, as it does not retain the bacteria.

Very exceptionally the bacteria may be carried down by a small excess of mucus derived from slight vesical catarrh. They then form a thin white layer on the bottom of the containing vessel, leaving the urine perfectly clear in about the middle part of the glass containing the urine. When bacterial urine is tested with a sensitive re-agent, a trace of proteid may generally be found; usually it is a compound proteid.

The bacterium coli commune is very irregular in duration; it sometimes occurs for a day or two and then spontaneously disappears, possibly recurring subsequently in a like fugitive manner. On the other hand, it may exist continuously for months. I observed a case here in Valhalla, in which the bacterium coli commune could be found continuously during three months in the urine, which was examined daily, once or twice.

I probably examined during my practice and laboratory work 5000—6000 urine specimens, but in nearly 3000 cases I found bact. coli commune. Playm and Laag (vide: Centralblatt fur Bakteriologie und Xsiten-Krankheiten 1895) reported a case, where acute urethritis was caused by bact. coli commune, it's simulated gonorrhoea. Consequently we must be very careful in doing differential diagnosis.

The bacillus lactis aerogenes, which occurs in the intestines occasionally finds its way into the urine and may be the cause of cystitis or of urithritis (vide: Warburg in the Munchener Medix, Wocheuschrift 1899. As the result of catherisation, with subsequent cystiltis, Horton Smith, (Journal of Pathology and Bacteriology 1897) found in the urine bacillus proteus urinae, which differs from other members of the proteus group.

To detect easily the tubercle bacilli in the urine, I have the honor to mention the Klein fluid, which was prepared in my laboratory. The papers regarding this very important matter and the fluid itself have been sent for approval to the Caroline Institute of the Stockholm University Sweden, and another copy to be read before the 7th International Congress against tuberculosis, to be held at Rome, Italy, April 14,-22, 1912. I would not like to discuss this matter before the definitive answers of the Caroline Institute and the Congress will be received.

I have been using the fluid in about 500 cases and found the tubercle bacilli in 75 per cent of the cases very quickly and surely. The typhoid bacillus is not infrequently present in the urine of patients who are suffering from enterica. It has been found in the early stage but is more common after the first or second week. It may continue to be present for many weeks or months. In septic endocarditis, erysipelas and other septic conditions staphylococcus pyogenes aureus, streptococcus pyogenes and occasionally other cocci are present. In female children affected with thrush, the spores and threads of Oidium Albicans may occur in the urine, if the disease has attacked the vulva.

Sarcinae occur in both acid and alkaline urines, and they are smaller and paler than the Sarcinae ventriculi. In dilatation of the stomach, Stein (in the Archives fuer medizin 1876) observes that if sarcinae are present in the contents of the stomach, the urine is usually acid; in dilatation with the absence of sarcinae, the urine is alkaline. And last, but not least, we forget about the gonococci, immense trouble for the bacteriologist to find them if few or chronic, etc.,—easily detected if acute, fresh, only a few days old. Of course they never disappear, only hard to detect. Methylene blue is not satisfactory—Gram's method, also. Why is so little research work done on this line? —although of immense importance. We had a general surgeon, Dr. Von..... T.....h, in Vienna, who thinks that "Ein jeder Tripper vergeht, nur der erste nicht, folglich sind immer gonococcen da!" Alors! That's enough!

A VISIT TO THE STATE HOSPITAL AT CHEROKEE.

EVALENE PEO, M. D., BOONE, IOWA.

This institution was built about ten years ago. It is a massive red brick structure with marble trimmings. It has a population of 1,100 souls, 950 patients, 150 more men than women. If we should take a walk and follow around the foundation of the main building when we got back to our starting point we would have walked one and one-half miles. It is built with a wing on each side of the main building, so built that no rooms or wards are without sunshine at some time during the day. The main or central part of the building is called the Administration building. The main floor is used for offices, the general superintendent and the offices of the different departments. The second floor of main building is the general superintendent's home. The third floor is used for the attending physicians and their wives. Fourth floor for nurses and attendants. The wings are used for patients, one for men and the other for women.

Divided Into Wards.

The buildings are divided in wards (24 wards) in number. These wards are long, wide halls, with a cross hall mid-way. These cross-halls are used for a general sitting room for the patients of this ward. The halls have rooms opening on each side, some rooms have two beds in them. The patients that occupy the same room are selected with care; so that they are congenial and will not annoy each other. They become very much attracted to each other and will hardly ever be separated. The walls are all painted and decorated with apples, violets and lily blossom designs, all very beautiful and restful to the eyes and nerves of these over nervous patients. Each ward has pictures and potted plants. The dormitories are similar to the wards in our general hospitals.

They have 8 to 12 beds in a dormitory. The dormitories open in the hall. The tubercular patients are all together in one dormitory and the mens' dormitory is similar to the women's.

Besides these they have what is spoken of as the sick wards where the patients are in bed part or all day, some part of the day, if they are able they are brought out to sit in the wide halls in the sunshine and visit with the other patients.

Given Best of Care.

The floors are all hard wood polished. Some of the more active restless patients and those who are physically able are allowed to polish the floors. They have a handle with a wide board padded with cloth and they push it ahead of them over the floors and this helps to keep them occupied for at least one or two hours a day. Every thing to help them

to regain their mental alance and restore their health seems to have been thought of. The doors of the sleeping rooms are latticed in two crossed panels so the patient is always under the watchful eye of the attendants. The patients when well enough are taken out for a walk around the grounds twice a day.

There are several large pavilions on the grounds with seats in for the patients to rest, sew and read in the open air. There is a good library, the books to be used by all. An art teacher is employed to teach the patients, and that helps to occupy their time and they do very beautiful work. Those that are able can and do help in the sewing room.

Besides the main building there is a cottage where the ones that help on the farm are housed, and a physchological building for men and women. This building is used for the new patients until classified. They also have a small laboratory where the physicians can use all the latest methods for diagnosis and treatment. They have an operating room, well equiped for a hospital not intending to make surgery a specialty, and a conservatory which furnishes cut and potted flowers for the wards and tables.

Attended Easter Services.

I attended Easter services at the chapel twice on Sunday. The decorations were beautiful, the decorations were all potted plants, palms, ferns, lilies and many other kinds. The ministers from the Cherokee churches conduct the chapel services. The first service was at 9:00 o'clock A. M. The afternoon service was a concert of sacred music. The patients seemed to enjoy these services very much.

The sleeping rooms all have white iron beds, white spreads and are as immaculate as any hospital I ever visited. There are one hundred and fifty employees, six physicians, two women and four men physicians, three besides the general superintendent who is a physician.

These physicians make three rounds every day visiting or seeing every patient. There is a physician on night duty that makes the same number of rounds. The general superintendent visits all patients at least once a day. You can readily see that your friends who are patients at these state hospitals are very carefully cared for.

All parts of the various buildings are connected by phone. The hospital has its own fire equipment and fire fighting force. The hydrotherapy rooms are on the first floor. These rooms are fitted up with electric light, baths, tubs for continuous baths, shower baths and salt rubs.

They give fifty therapeutic baths a week besides the regular baths. In the basements also are the laundry rooms and bakery. The laundry has six electric washers and 2 large electric wringers and very large mangle. They have large sewing rooms as the state has to furnish

most of the clothing for the patients. The farm consists of 1,000 acres well stocked. There are 125 milch cows.

Patients Are Well Fed.

There are four kitchens and four dining rooms. I would like to give you an idea of the amount of food prepared each day.

Five and one-half barrels of flour is baked up every day, 30 bushels of potatoes cooked each day. 380 pounds of meat cooked each day. 35 pounds of coffee used each day. 7 pounds of tea. Forty-five gallons of milk for breakfast alone. 65 pounds oat meal for breakfast. Kraut one barrel a day. 125 pounds of raisins a day. 173 large pies a day. 13,000 cookies a day. 595 dressed chickens for one meal. 250 pounds frankfurters for one meal. 150 pounds of liver for one meal. 150 pounds of bacon for one meal. 700 pounds of cabbage for one meal. 400 pounds of parsnips for one meal. 400 pounds of carrots for one meal. 600 pounds of turnips for one meal. 150 bushels of lettuce for one meal. 8 bushel of onions for one meal. 10 gallons of jelly for one meal. 45 gallons of canned fruit for one meal. 8 cases of eggs, 2 eggs for each person and three for the working cottage. 73 pounds of hominy for one meal. 73 pounds of rice for one meal. 1,110 pounds of sugar for one week. 1 car load of coal used daily. $10,000 of clothing bought yearly. 500 suits of men's clothing now ordered for next year. 450 shirts now made for next year. The matron oversees four kitchens, four dining rooms, the laundry and sewing rooms, also the poultry yard. Everybody is busy.

I am thoroughly convinced that in no other hospitals are our sick friends any more carefully cared for or more kindly treated by one and all than in our state hospitals and to the people of our state, who have friends cared for in these state hospitals you can feel sure they are well cared for and kindly treated.

From Boone News-Republican.

Said a young physician of the new school: "Do you know it makes a heap of difference how you apply remedial agents? Thirty drops of turpentine to a dog by mouth makes him pass a ten-foot tape worm. The same thirty drops per rectum would make him pass a seven cylinder motor car at the speed limit. So there you are. It all depends."

—W. Bodemann, *Indianapolis Medical Journal.*

The frog croaks because croaking is his business. You croak because—?

IOWA MEDICAL JOURNAL

A Monthly Journal
Devoted to the Interests of the Iowa Profession

E. E. DORR, M. D. Editor and Proprietor.

Subscription $2.00 per year, in advance.

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Physician's Cards, $5.00 per year. Advertising Rates.

We request short papers and reports of cases from Iowa Doctors. All papers should be typewritten. Reprints furnished at cost and should be ordered when paper is sent us, as it saves expense.

We want papers from county societies.

OUR PLATFORM.

The Improvement of the Health of Iowa People.
The Improvement in Hygienic Conditions in all Iowa Cities.
The Improvement of the Profession, Individually and Collectively, in the Art and Science of Medicine.
The Improvement in Legislation so as to require High Attainments of every Practician, regardless of his School or Pathy.
The Improvement in Organization, making every legally Registered Physician of Good Standing in his Community a Member of his County and State Society.

Vol. XVIII Des Moines, June 15, 1912 No. 12

The Fakirs in Iowa.

Up in Clay County they do things to the grafters and especially those attempting the practice of medicine without licenses.

In April information was filed against some itinerants known as the Hackett Gang. This bunch had been selling dope without a license and also prescribing contrary to law.

The attorney for Clay County had them all pinched and bound over under bonds to await the action of the Grand Jury. One man was deserted by his pals and had to stick it out in jail.

The evidence against the men is so overwhelming that there is no doubt but that every one will get what is coming to him and the limit that the law prescribes.

Great credit is due the medical men of Clay and the Secretary of the State Board in the prosecution of these men.

Prosecutions have been made from time to time during the last twenty years and in most instances the fakir has been given the limit

of the law, but for some reason the life of the medical swindler is so alluring that there are others always ready to try.

As in most criminal prosecutions, it is not the criminal that suffers most but the family of those who have over-reached the mark. As in the instance of one of the men arrested in this bunch, a sick wife and a destitute family suffer both the humiliation and the pangs of want, while the culprit lies out his sentence in jail.

The County Hospital.

Cherokee County physicians are intending to take advantage of the law passed three years ago by the legislature, permitting counties to vote, for the building of a county hospital.

Washington County was the first to secure the vote and the hospital.

Other counties have followed and the plan is working well where tried. In Clay County the physicians were not unanimous in their desire for a hospital, and the fight became very bitter and was carried into the campaign for state officers.

We mention this contest because it was through the personal efforts of Dr. E. E. Munger of Spencer, that the bill was passed. Representative Felt of Clay made a hard and persistant fight for the bill and every one, fully cognizant of its provisions and the needs of the farming districts, considered it an advance movement.

Much better care and much stimulus to better work by the physician will be the result.

It is surely a progressive move and we hope that many of the counties in the state will take advantage of the opportunity to secure hospitals.

The Need of Health Ordinances.

A committee from Polk County Medical Society, composed of T. F. Duhigg, E. E. Dorr, and J. W. Osborn, state secretary, was appointed at the May meeting to assist the health department of the city in formulating some health ordinances for the protection of the people of Des Moines.

Many cities have health ordinances covering the protection of foods, fruits, candies, etc., regulating hotels and boarding houses as to sanitary conditions, also street cars and carriages; also defining what shall and shall not be done in restaurants, such as, the serving of individual butter dishes, lump sugar, the sterilization of drinking glasses, etc., as well as the discontinuance of the common drinking cup.

To those familiar with the common utensil, the plan will appeal strongly.

In a restaurant, not long since, we saw a man wipe a teaspoon on his coat-tail, lick it off afterwards with his tongue and insert it into the sugar bowl.

We have seen men clean their knives in their mouths and then help themselves to butter from the common dish on the table.

And we have seen a syphilitic, with numerous patches on lips and tongue, using the common drinking glass at the water bottle, in the hall on our office floor.

What we have seen is being repeated every day, in the cities of our country, and the boarding houses of working gangs everywhere.

Why a grocer will put his apples, potatoes and onions in boxes and place on the sidewalk, to serve as a target for every street dog is more than the sanitary mind can fathom.

It seems to us that every food product eaten without first sterilizing, should be protected from flies, dust and filthy air.

Candies should be kept in glass protected cases. Meats should not be exposed on counters except to cut or wrap. Bread should be wrapped before leaving the oven room of the bakery. Apples, grapes, in fact any food eaten raw should be as well protected as meats and bread.

It will be better to go too far in protecting the health of our people than not far enough.

The Iowa physicians who attended the meeting of the A. M. A. at Atlantic City report a most enjoyable time. Those who registered from Iowa are as follows:

Barstow, James M., Council Bluffs.
Bierring, Walter L., Des Moines.
Dean, Lee W., Iowa City.
Doty, E. A., Oxford.
Fairchild, D. S., Clinton.
Fay, Oliver J., Des Moines.
Guthrie, J. R., Dubuque.
Haecker, Lewis E., Hampton.
Jarvis, E. T., Cedar Rapids.
Keogh, John V., Dubuque.
Kessler, J. B., Iowa City.
Meanes, Lenna L., Des Moines.
Powell, C. B., Albia.
Applegate, C. F., Mt. Pleasant.
Langan, J. C., Clinton.
Spaulding, Homer L., Ankeny.
White, Herman A., Clinton.
Witte, Max E., Clarinda.
Littig, Laurence W., Davenport.
Ranson, Pauline Myers, Marshalltown.
Wight, A. L., Carroll.
Priestley, James Taggart, Des Moines.
Bond, L. Lafayette, Denison.
Donohoe, George, Knoxville.
Ghrist, Jennie G., Ames.
Jenkins, Hugh, Preston.
Hobson, Abraham J., Hampton.
La Force, E. F., Burlington.
Lewis, E. R., Dubuque.
Magee, C. H., Burlington.
Munger, E. E., Spencer.
Patterson, J. N., Burlington.
Pearson, William W., Des Moines.
Peck, John H., Des Moines.
Rockafellow, John C., Des Moines.
Smith, S. J., Iowa City.
Vest, William E., Des Moines.
Weber, J. S., Davenport.
Voldeng, M. N., Cherokee.

SOCIETY REPORTS.

POCAHONTAS

County Medical Society held an interesting session on May 1, in Pocahontas.

Dr. A. L. Belt of Ft. Dodge, read a paper on "Minor Ailments and Their Treatment," which was voted a success. Dr. W. W. Beam opened the discussion. Dr. J. C. Riordan read a paper on "Our Limitations in the Application of Remedies," which brought out a free discussion.

Much interest is taken by the medical men in this association and it is planned to have weekly meetings from now on.

HANCOCK

County Medical Society met in Garner, June 1. Six new members were admitted

The meeting was devoted to the study of clinical cases and many interesting cases were reported. Dr. A. J. Cole was elected president, and Dr. E. A. Couper, secretary. The next meeting will be held in Britt.

JONES

County Society met in Anamosa, May 28, with a large attendance.

The papers were read by Dr. S. Druet, Dr. F. B. Sigworth and Dr. F. C. German of Anamosa, Dr. L. M. Redmond, Dr. W. W. Hunter and L. G. Stuhler of Monticello, and Dr. Wm. Breen of Oxford Junction.

CLAYTON

County Medical Society met at the Clark Hospital in McGregor, May 15, and enjoyed a very able program. The attendance was large and all enjoyed the occasion. The next meeting is to be in McGregor.

BREMER

County Medical Society held a meeting at Dr. Rohlf's office in Waverly, Iowa, June 5. There was a good attendance and evidence of an increasing interest in the meetings. Dr. E. E. Wuttke of Sumner was made a member. The non-members present, were Dr. Sparks of Westgate, Dr. Thierman of Aredale and Dr. Ensley of Shell Rock.

Three very interesting and instructive papers were read; one on "Otitis Media," by Dr. R. E. Robinson, one on "Angio Neurotic Oedema," with report of two cases by, by Dr. O. L. Chaffee, and one on "Pneumonia," by Dr. C. H. Graening. These were all followed by a general discussion.

Waverly was agreed upon as a permanent meeting place of the society, the next meeting to be held in September. Dr. Harry H. Ennis, secretary.

BLACK HAWK

County entertained Dr. A. M. Pond of Dubuque, at its meeting May 24. The Subject of Dr. Pond's paper was "The Immediate and Remote Causes of Gall Stones," and it was enjoyed by a large attendance.

Plans were completed for the annual picnic and a spirit of good fellowship prevailed.

CLINTON

County Society met on June 7, in the grill room of the Kehoe Hotel in Clinton.

After luncheon, Dr. Grace Schermerhorn read a paper on "Infections Following Child-birth, Their Prevention and Treatment." Such an interesting subject naturally was appreciated. The discussion was led by Drs. M. S. Jordan and Kurt Jaenicke.

Much friendly feeling has been manifested as a result of these luncheons.

DES MOINES

County Medical Society entertained the State Society in splendid shape last month. They had received the promise of the Commercial Exchange of as much money to defray the expenses as they had raised in the society.

After all bills were paid the County Society informed the Exchange that they would not call on them for their donation and asked that their portion be turned into the general convention fund, and further offered to donate for the large electric "WELCOME" sign, constructed on the river front.

POLK

County Medical Society had its May meeting on the 28th, with a large attendance. Dr. A. Steindler delivered an address on the "Treatment of Chronic Arthritis," showing numerous X-Ray pictures and lantern slides. Dr. M. L. Turner read a paper on "The Treatment of Normal Puerperium," which elicited free discussion.

A committee was appointed to assist the City Health Department in formulating an ordinance protecting food stuffs, and arranging sanitary standards for public conveyances, hotels, rooming houses, etc.

NORTHEASTERN IOWA

Medical Society held its first meeting in Calmar June 11, 1912, with the following program: Report of Committee on Constitution and By-Laws, Dr. G. A. Plummer, Cresco; Dr. F. A. Hennessey, Calmar; Dr. F. S. Feeneny, New Hampton; Paper, "Pemphigus," Dr. Jewell; Discussion, Dr. Kaasa; Paper, "Some Points in the Prevention, Prophyaxis Diagnosis and Treatment of Typhoid Fever," Dr. W. C. Hess; Paper, "Treatment of Typhoid Fever with special Reference to Forced Feeding," Dr. F. R. Sparks; "Discussion on Typhoid Fever," Dr. F. W. Lee, Dr. Kessell. Dr. W. C. Hess, Secretary-Treasurer, Dr. P. M. Jewell, President.

BOOK REVIEWS.

CASE HISTORIES IN NEUROLOGY.

A selection of histories setting forth the diagnosis, treatment and post-mortem findings in nervous disease, by E. W. TAYLOR, A. M., M. D., Instructor in Neurology, Harvard Medical School; Assistant Physician, Department of Neurology, Massachusetts General Hospital; Visiting Neurologist, Long Island Hospital, Boston. W. M. Leonard, publisher, Boston.

Dr. Taylor has reported 109 cases as to diagnosis, prognosis and treatment that will interest the general practitioner very much.

The detailed work of a man with the experience of Dr. Taylor can not help but be appreciated by every student in the practice. Most studies in neurology demand an unusual amount of time and labor but in the history reports as given here, the interest is maintained and comparisons drawn that certainly should save much time and maintain the interest in work.

CASE HISTORIES IN MEDICINE.

Illustrating the diagnosis, prognosis and treatment of disease, by RICHARD C. CABOT, M. D., Assistant Professor of Clinical Medicine, Harvard Medical School. Second Edition, Revised and Enlarged. Price, $3.00 net. W. M. Leonard, publisher, Boston.

The theory and practice is very interesting but the experience and

results of practice by successful practitioners lends something to the conclusions of diagnosis.

Case reports covering one hundred examinations and recommendations in treatment are apt to offer some startlingly similar details to some of the cases you have had under observation. If it does, you are the one greatly benefited, and in this work you will doubtless find many that will remind you of those at home.

If one reported case helps you in a diagnosis you are repaid the value of the work.

PSYCHOTHERAPY.

Including the history of the use of mental influence, directly and indirectly, in healing and the principles for the application of energies derived from the mind to the treatment of disease, by JAMES J. WALSH, M. D., Ph. D., Dean and Professor of Functional Nervous Diseases and of History of Medicine at Fordham University School of Medicine, and of Physiological Psychology at the Cathedral College, New York, Fellow of the New York Academy of Medicine, etc. D. Appleton and Company, publishers, New York and London.

No doubt much has been done in the aleviation of pain and suffering, by mental suggestion.

A study of conditions in which psychotherapy can be used to advantage should interest every practitioner, as it is to his, as well as the patients benefit, if relief can be secured.

The prejudice against the use of medicines is noticeable daily in the practice of the general physician and he often longs for some straw to grasp in order to save his patient and, incidentally, himself.

Fads and fancies in the practice, owe their success in the application to cases, and where one may stick, a dozen may fail.

Dr. Walsh has written a book that furnishes a large discussion to the proper application, or the application at the proper time. The book is interesting and instructive.

REPORT FROM THE PATHOLOGICAL DEPARTMENT

and the Department of Clinical Psychiatry, Central Indiana Hospital for the insane. 1909-1910 and 1910-1911.

This is the fourth annual statement of the department of pathology of this institution, and deserves consideration, particularly from the alienists. The report is well prepared.

1911 REPORT OF PUBLIC HEALTH AND MARINE HOSPITAL SERVICE.

Annual report of the Surgeon General of the Public Health and Marine Hospital Service of the United States, for the fiscal year, 1911, Washington government printing house.

FALSE MODESTY.

That protects vice by ignorance, by E. B. LOWRY, M. D., author of "Confidences," "Truths," Herself," etc. Price, $.50. Forbes and Company, publishers, Chicago.

Dr. Lowry offers another of his small studies in sex teaching and hygiene.

We have carefully and fully read this little volume and do not hesitate to recommend its use. There is nothing in it that could offend the most delicate female mind nor offer evil suggestions to the growing boy. In fact it should be put before both the boys and girls with the injunction to read and remember.

PRACTICAL MEDICINE SERIES (VOLUME I).

General Medicine.

Edited by FRANK BILLINGS, M. S., M. D., Head of the Medical Department and Dean of the Faculty of Rush Medical

College, Chicago, and J. H. SALISBURY, A. M., M. D., Professor of Medicine, Chicago Clinical School. Series, 1912. The Year Book Publishers, Chicago.

As might be expected, the reviews of the advancements in medicine during the last year have been numerous and valuable.

This volume reviews the literature for the year and contains editorial comment on such changes in diagnosis and treatment as has proven especially worthy.

Among the plans for outdoor treatment there have been developed some common sense as well as scientific ones.

The results of the study of heart disease have led to numerous suggestions in the diagnosis of heart lesions, and in treatment.

PRACTICAL MEDICINE SERIES (VOLUME II).

General Surgery.

Edited by JOHN B. MURPHY, A. M., M. D., LL. D. Professor of Surgery in the North Western University. Attending Surgeon and Chief of Staff of Mercy Hospital, St. Joseph's Hospital, and Columbus Hospital, Consulting Surgeon to Cook County Hospital and Alexian Brothers Hospital, Chicago, Illinois. Series 1912. The Year Book Publishers, Chicago.

Under the direction of John B. Murphy, this book reviews the work in surgery of 1911. Some recommendations in technique are given but the greatest improvement seems to be in blood vessel and bone surgery.

Other branches of the art are not neglected. Some valuable suggestions are given regarding anesthesia with the use of narcotics before operation.

The review of intestinal and stomach surgery receives extended mention.

MEDICAL NEWS NOTES.

Dr. Turner of Colfax, has returned from Canada.

Dr. W. E. Alton of Ft. Dodge, has returned from California.

Dr. J. W. Cain of Waukon, was badly bruised in a runaway, in May.

Dr. and Mrs. John Herman of Sioux City, sailed for Europe about May 20.

Dr. E. C. Lawrence of Des Moines, recently left for a trip through the south.

Dr. O. A. Pitcher of Mt. Pleasant, is suffering from a stroke of paralysis.

Dr. C. M. Walters and family of Bancroft, have returned from California.

Dr. E. B. Howell of Ottumwa, has been taking a post graduate course in Chicago.

Dr. A. Babcock of New Hampton, sailed May 16, for England and the Continent.

Dr. H. T. Walker of Dubuque, is slowly recovering from an operation for appendicitis.

Dr. I. D. Kauffman of State Center is recovering from an operation for appendicitis.

Dr. A. R. Brackett of Charles City, spent several days in May fishing at Spirit Lake.

Dr. Van Buren Knott of Sioux City, has returned from a month's hunting trip in Oregon.

Dr. I. E. Nervig of Sioux City, took a post graduate course at the Mayo Hospital, in May.

Dr. and Mrs. Oliver J. Fay of Des Moines, are enjoying a vacation, visiting in the east.

Dr. E. C. Rawson of Strawberry Point, spent the latter part of May in Crookston, Minnesota.

Dr. and Mrs. C. W. Spaulding of Carroll, have returned from a visit with their son, in Denver.

Dr. C. C. Smith of Clarksville, fell from a tree while sawing off a limb and broke a bone in his leg.

Dr. Fred Jarvis and wife of Oskaloosa, have returned from an extended tour of the Pacific Coast.

Ward Hanna of Vinton and William Redmund of Dysart have been granted physicians certificates.

Dr. Georgia Stewart of Des Moines, talked on "The Early Diagnosis of Cancer," at Burlington, June 7.

Dr. A. Anderson of Sioux City, has returned from a trip to Jacksonville, Florida, and other southern cities.

Dr. Rodney P. Fagan of Drake University, has been appointed interne at the Mercy Hospital, Des Moines.

Dr. T. H. Stull of Algona, who has been confined to his home during the winter, recently suffered a paralytic stroke.

Dr. F. H. Cutler of Cedar Falls, attended the meeting of the Illinois Central railway surgeons in Chicago, in May.

Dr. Ida G. Rhodes of Waterloo, was called to the bedside of her mother in Gibson City, Illinois, in the latter part of May.

Dr. G. H. Mammen of Le Mars, attended the meeting of the surgeons of the Illinois Central Railway in Chicago, in May.

Dr. and Mrs. T. A. O'Brien of Emmetsburg, have returned from St. Louis, where they have been for the last few months.

The young daughter of Dr. and Mrs. F. E. Welsh of Boone, has been seriously ill with typhoid fever, but is now convalescing.

The new addition to St. Joseph's Hospital, Sioux City, has been completed, making an additional capacity of sixty-five rooms.

The Eleanor Moore Hospital of Boone, has been going through its yearly house cleaning, and is very much improved in looks.

Dr. H. M. Bradley of Manchester, attended the meeting of the surgeons of the Illinois Central Railway, held in Chicago, in May.

Dr. J. W. Dixon and family of Burlington, have arrived home from their river trip to New Orleans, where they spent the winter.

Dr. J. E. Morgan has resigned from his position as health officer of Oskaloosa. His successor will be Dr. S. W. Clark of that place.

Dr. D. W. Stumbaugh of Lacona, was attacked by a robber May 24, and besides having $75.00 taken was very seriously, if not fatally hurt.

Dr. T. W. Bennett of Lenox, spent a couple of weeks in May, taking treatment at Colfax. He reports very little improvement in his health.

Dr. F. W. Stewart and family of Colfax, are spending several weeks visiting in Pennsylvania. They are making this delightful trip in their automobile.

Dr. N. T. Weston of Colfax, has returned from Garvin, Minnesota, where he has been for several weeks looking after business interests.

Dr. and Mrs. M. W. Moulton of Bellevue, write from Gibralter that they have had a very pleasant trip. Their next stop will be Algiers, Africa.

Dr. Joseph R. Winnett and Dr. Edgar Earwood of Drake Uni-

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Announcements will be sent upon application to **Ross V. Patterson, M. D., Sub-Dean**

versity have been appointed internes at the Iowa Methodist Hospital.

Mrs. Rood, wife of the late Dr. L. D. Rood of Des Moines, has given an X-Ray Machine to the Ridge Camp Tuberculosis Hospital, Des Moines.

Dr. H. C. Worthington of Charles City, spent several days of May in Chicago visiting his daughter Dorothy, who is attending school in that place.

Dr. and Mrs. M. N. Volding of Cherokee, went to Atlantic City early in June, where the doctor attended the meeting of the American Medical Association.

Mrs. Margaret Grismore has resigned as superintendent of Bellevue Hospital in Muscatine. Mrs. Grismore expects to spend several months in Sweden.

Dr. Esther Ryerson of Mt. Pleasant, has given up her trip to California, and will assist her friend Dr. Florence Sherbon of Colfax, during the summer months.

Dr. W. A. Vincent of Belle Plaine, was ill in May. He was completely worn out after attending Mrs. Vincent through a long seige of typhoid fever and pneumonia.

Dr. C. C. Haskell, of the Pharmacological Department of Eli Lilly & Company, was in attendance at the Atlantic City meeting of the American Medical Association.

Dr. and Mrs. C. F. Applegate of Mt. Pleasant, went to Atlantic City, early in June, where the doctor attended the meeting of the American Medical Association.

Dr. F. C. Smith of Mt. Ayr, recently underwent an operation in the Mayo Brothers Hospital at Rochester, Minn. He has returned home and is convelscing rapidly.

Dr. and Mrs. J. G. Evans of New Hartford, spent several days of May, in Chicago, where the doctor was attending a meeting of the Illinois Central railway surgeons.

Dr. Nelle Noble of Des Moines, read a paper on "The Importance of Good Milk and Water Supply," at the annual meeting of medical women held at Burlington, June 7.

Dr. and Mrs. W. E. Alton of Ft. Dodge, accompanied by a party of friends, are on a cruise down the Mississippi. They expect to visit Miami, Florida, before they return.

Dr. W. M. Young of Jefferson, has returned from a two month's stay in the East, spent in taking special post graduate work at Harvard University and in New York City.

Dr. H. A. Leipziger has returned to Burlington, having given up his trip to Europe. Upon arriving at New York City, he found his father very ill and remained there to give him his attention.

Notes of personal happenings, weddings, births, change of location, etc., sent direct to the Journal are greatly appreciated by us. These columns are yours and it is your privilege to help make them.

Dr. T. L. Putnam of Shenandoah, had his finger badly bitten recently by a small child. The little one was very ill and Dr. Putnam was forced to plunge his finger down its throat to restore breathing.

Dr. E. E. Munger of Spencer, read a paper on "Hospitals and the Health Problems with Special Reference to the Necessities of Rural America," before the American Medical Association at Atlantic City.

Dr. and Mrs. F. L. Woodburn of Washington, but formerly of Ainsworth, have returned from Phoenix, Arizona, where they had gone for the doctor's health. We regret to say that he is very little improved.

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Florence Brown Sherben, M.D. } Physicians in Charge

T. C. Hullman, Manager
Minnie V. Updegrove, Supt. Nurses

The Physicians Casualty Association of Omaha, has made such a success that its officers have installed a health department, and the secretary informs us that 1200 policies were written in the first sixty days after beginning the work.

Dr. T. S. Waud of Germania is making arrangements for an excursion to Germany, which is expected to leave Germania about September 15. At the present time, fifteen or twenty have signified their intentions of joining the party.

Dr. Velura E. Powell of Red Oak, attended the meeting of the American Medical Association at Atlantic, and on her way home, stopped at Cleveland to attend the Conference of Charities and Corrections, to which she had been appointed as delegate from Iowa, by the governor of the state.

Dr. Clarence W. McConihay is a new addition to the medical fraternity of Des Moines and is assistant physician at the Retreat. He graduated from Charleston, West Virginia High School, attended University of West Virginia and graduated from Jefferson Medical College in 1910. He served an Internеship of eighteen months in Philadelphia General Hospital, three months of which was in the service of Dr. T. H. Weisenburg, in the study of diseases of the nervous system. There, and at that time, he was also under the guidance of Dr. Charles K. Mills.

Dr. Conihay has spent a few months each in the Sheltering Arms Hospital in Hansford West Virginia, and in the Philadelphia Hospital for contagious diseases.

Dr. Weisenburg says of him:

"He is a very nice fellow personally, a gentleman, a good student and I think will make an excellent man. Of all the men who have presented themselves, I think he is the most acceptable."

Dr. Mills writes:

"I know Dr. McConihay, he having served as my interne at the Philadelphia General Hospital. I also know him through professional friends in Philadelphia. From this knowledge I believe Dr. McConihay would prove an efficient and acceptable assistant, being capable of doing both good general and special work. His personality also appears to me to be such as to make him desirable for a position like that which he seeks."

CHANGE OF LOCATION.

Dr. R. T. Van Metre of Dow City, has located in Fremont, Nebraska, where he will continue to practice medicine.

Dr. J. E. Meyer of Lansing, has located in Gray.

Dr. E. E. Warner of Nevada, has located in St. Peters, Minnesota, where he will have personal charge of a private sanatarium.

Dr. A. L. Haynes, of Toledo, is now located at Grand Valley, South Dakota.

Dr. F. J. Smith of Des Moines, has recently returned to Milford, Iowa, for his summer outing.

Dr. E. J. Liechty formerly of Alexandria, South Dakota, is now located at Kingsley, Iowa.

BIRTHS.

Dr. and Mrs. A. P. Stewart of Inwood, are happy over the arrival of a little daughter, born May 24.

Dr. and Mrs. Benjamin Sherman of Dexter, are the happy parents of a baby daughter, Marjorie, born May 3.

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DISPENSARY CLINICS—The University Dispensary, 406 Center street, now offers a daily service in the departments of pediatrics, neurology and general medicine, genito-urinary, orthopaedic and general surgery, eye, ear, nose and throat, germatalogy and gynecology.

A tuberculosis dispensary service is conducted on Tuesday and Friday forenoons.

HOSPITAL CLINICS—The College enjoys control of the clinical cases in the Iowa Methodist Hospital, Mercy Hospital, the Salvation Army Rescue Home, the City Detention Hospital, the County Hospital, and in other smaller hospitals in the city of Des Moines, the total number of beds exceeding 500, and furnishing clinical material in every branch.

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WEDDINGS.

Dr. E. L. Reincke and Miss Dollie Baynes both of Dubuque, were married Wednesday, May 15, at the home of the bride.

Dr. John E. Garver of Sioux City, and Mrs. Clarissa Eva of Le Mars, were married in Le Mars, Wednesday, May 1.

DEATHS.

Dr. J. Worley of Belle Plaine, died at his home, May 14. Dr. Worley was 78 years old and had lived in Belle Plaine for many years.

Benjamin Nichols, father of Dr. H. H. Nichols of Marshalltown, died May 15, after eating what he supposed was mushrooms.

Dr. L. F. Allen of Tama, company surgeon for the Milwaukee, died at his home, May 27. He was the father of Dr. L. E. Allen of Perry.

AUTO NOTES.

Dr. I. O. Pond of Sioux City, has traded his Ford touring car for an Overland.

Dr. O. M. Landon of New Hampton, met with an accident, a short time ago, when in an attempt to start his machine the crank hit him in the wrist, tearing loose a number of ligaments.

Dr. W. S. Kyle of Shannon City, has recently purchased a new Ford Roadster.

Dr. E. Mitchell is the recent purchaser of a new machine.

Dr. J. D. Geissinger of Spirit Lake, is the owner of a new Page Detroit.

Dr. E. K. Tyler of Muscatine, recently returned from Chicago, in a new machine.

Dr. E. J. Butterfield of Dallas Center, is the recent owner of a Ford Car.

Dr. and Mrs. Thomas Bond of Des Moines, enjoyed an overland trip to Michigan in their new machine.

Dr. F. C. Mehler of New London, has a new machine.

Dr. W. A. Garner of Kiron, has recently purchased a new machine.

Dr. C. E. Birney of Estherville, has a new machine.

Dr. I. N. Crow of Meringo, is a very recent owner of a Hudson.

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WANTED.—A position during the summer vacation with a busy practitioner, or to take charge of his practice during his vacation. I am a senior medical student 28 years old, married. I am the son of an Iowa physician, and have had considerable experience and the best of advantages. Best of references given. Address S care Iowa Medical Journal.

WANTED.—By Senior student of Drake Medical School, a place with practitioner until September. References given by the faculty. Address K. D. F., care Iowa Medical Journal.

Index to Volume XVIII, July 1911-June 1912 Inclusive.

ABDOMINAL ADHESIONS—MAX EMMERT, M. D., Atlantic, Iowa..... 212
ALCOHOL IN MEDICINE—WM. F. WAUGH, M. D., Chicago, Illinois..... 134
BILE DUCT, OBSTRUCTION OF THE COMMON, DUE TO CANCER OF THE AMPULLA—J. W. RICHARDS, M. D., Mechanicsville, Iowa..... 466
CANCER, THE LAST THEORIES ON—S. R. KLEIN, M. D., PH. D., Valhalla, New York 287
CARCINOMA OF THE UTERUS, DIAGNOSIS OF—J. H. MAYNARD, M. D., Adair, Iowa 360
CARCINOMA OF THE UTERUS, PATHOLOGY OF—D. J. GLOMSET, M. D., Des Moines, Iowa 307
CARCINOMA OF THE UTERUS, THE PROPHYLAXIS AND CURE OF—H. A. MINASSIAN, M. D., Des Moines, Iowa..... 316
CARE OF THE EXPECTANT MOTHER—MAUDE TAYLOR, M. D., Ottumwa, Iowa 319
CHILD LIFE, THE PROTECTION OF—CHAS. O. PROBST, M. D., Columbus, Ohio.. 381
CROSSED EYES IN CHILDREN, THE NON-SURGICAL TREATMENT OF—R. H. PARKER, M. D., Des Moines, Iowa..... 582
CYSTOSCOPY AS AN AID TO DIAGNOSIS—R. A. WESTON, M. D., Des Moines, Iowa 331
DIPHTHERIA CARRIERS AND MEDICAL INSPECTION OF SCHOOLS—HENRY ALBERT, M. D., Iowa City, Iowa..... 261
DIRECTORY OF IOWA PHYSICIANS, BY COUNTIES..... 149
DIRECTORY OF IOWA PHYSICIANS, ALPHABETICALLY..... 172
ETHER, THE ADMINISTRATION OF FOR GENERAL ANAESTHESIA—J. E. BRINKMAN, M. D., Waterloo, Iowa..... 233
EYE, EAR, NOSE AND THROAT, CLINICAL BRIEFS ON—RALPH H. PARKER, M. D., Des Moines, Iowa..... 196
EXOPHTHALMIC GOITRE, WITH A REPORT OF AN INTERESTING CASE—DAVID L. RUNDLETT, M. D., Sioux Falls, South Dakota..... 220
GLANDULAR FEVER, SOME OBSERVATIONS ON—J. HERBERT DAREY, A. M., M. D., Sioux City, Iowa..... 129
GOITRE—C. B. TAYLOR, A. M., M. D., What Cheer, Iowa..... 407
GRAND CANYON, A DAY AT—A. G. FIELD, M. D., Des Moines, Iowa..... 132
HEART, PATHOLOGICAL PHYSIOLOGY OF THE—W. L. MENDENHALL, M. D., Des Moines, Iowa..... 471
HYSTERO-EPILEPSY (A CASE) F. T. ROBERTS, M. D., Ft. Madison, Iowa..... 432
IOWA, THE MEDICAL ASPECT OF—A. G. FIELD, A. M., M. D., Des Moines, Iowa 535
JEALOUSIES, OUR—L. E. NEWCOMBER, M. D., Mason City, Iowa..... 81
LABORATORY FOR THE GENERAL PRACTITIONER, THE IDEAL—A. L. GROVER, Iowa City, Iowa..... 412
LABOR IN DEFORMED PELVES AND ITS TREATMENT—H. M. STOWE, M. D., Chicago, Illinois 324
MALIGNANCY—G. W. HINKLE, M. D., Harvard, Iowa..... 292
MALIGNANCY—G. W. HINKLE, M. D., Harvard, Iowa..... 427
MEDICAL PRACTICE, PORTO RICO—C. E. RUTH, M. D., Des Moines, Iowa..... 421
MEDICINE, CLINICAL BRIEFS IN—WALTER L. BIERRING, M. D., Des Moines, Iowa 91
MEDICINE, PROGRESS IN—N. C. SCHILTZ, M. D., Des Moines, Iowa..... 65
MIDDLE EAR CATARRH, PRACTICAL CONSIDERATION OF—H. G. LANGWORTHY, M. D., Dubuque, Iowa..... 215
MUSCLE BALANCE VS. DUCTION TESTS—FRED C. LA GRANGE, M. D., Denver, Colorado 377
MYELOCYTIC LEUKEMIA—J. H. PECK, M. D., Des Moines, Iowa..... 266
NERVOUS AND MENTAL DISEASES, SOME INFLUENCES IN THE LIFE OF TODAY PRODUCTIVE OF—F. A. ELY, M. D., Des Moines, Iowa..... 364
NEUROLOGY, CLINICAL BRIEFS IN—F. A. ELY, M. D., Des Moines, Iowa..... 38
NEW-BORN, HEMORRHAGIC DISEASES OF THE—L. E. KELLEY, M. D., Des Moines, Iowa 591
NURSING, STANDARD OF—MISS LUELLA BRISTOW, Ann Arbor, Michigan..... 41
OCCULT BLOOD AND ITS SIGNIFICANCE IN THE TREATMENT OF GASTRIC ULCER, J. T. STRAWN, M. D., Des Moines, Iowa..... 277
ORTHOPEDICS, CLINICAL BRIEFS IN—ARTHUR STEINDLER, M. D., Des Moines, Iowa 140
OSTEOPATHY, MY OBSERVATIONS IN EIGHT YEARS OF—W. A. RUSH, O. M. D., Omaha, Nebraska..... 25
OZONE—W. A. GUILD, M. D., Des Moines, Iowa..... 370
PNEUMONIA IN CHILDREN—THOS. P. BOND, M. D., Des Moines, Iowa..... 577
POLIOMYELITIS—JOSEPH M. AIKEN, M. D., Omaha, Nebraska..... 507
POLIOMYELITIS, ACUTE ANTERIOR—PETER BASSOE, M. D., Chicago, Illinois 53
POLIOMYELITIS, ANTERIOR OR INFANTILE PARALYSIS—C. E. RUTH, M. D., Ponce, Puerto Rico..... 63
PREGNANT UTERUS DIDELPHYS—A. E. ACHER, M. D., Ft. Dodge, Iowa..... 32
PRESIDENTS ADDRESS—L. W. LITTIG, M. D., Davenport, Iowa..... 557
PREVENTABLE DISEASES, THE ECONOMIC WASTE OF DISABIBLITY AND DEATHS DUE TO—ARETAS E. KEPFORD, State Board of Control..... 458
PROSTATECTOMY, POST OPERATIVE TREATMENT FOLLOWING—LEWIS WINE BREMERMAN, M. D., Chicago, Illinois..... 271
PROLAPSIS UTERI WITH COMPLETE EVERSION—C. O. WILKINS, M. D., Ft. Madison, Iowa 436
PRURITUS ANI—DONLY C. HAWLEY, A. B., M. D., Burlington, Vermont—(Extract from Paper read before the American Proctological Society at Los Angeles)..... 137
PUERPERIUM, TREATMENT OF NORMAL—M. L. TURNER, M. D., Des Moines, Iowa 586

RECTAL SURGERY, THE LIMITATIONS OF THE USE AND THE METHODS OF EMPLOYING LOCAL ANAESTHESIA IN—LEWIS H. ADLER, JR., M. D., Philadelphia, Pennsylvania 138
RECTUM, FOREIGN BODIES IN THE—T. L. HAZZARD, M. D., Pittsburg, Pennsylvania 139
RESPONSIBILITY IN REFERRED CASES, DIVISION OF—J. W. KIME, M. D., Ft. Dodge, Iowa 346
RIGHT LIVING AND GOOD HEALTH—JOSEPHINE W. RUST, M. D., Grinnell, Iowa 437
ROENTGEN RAY DIAGNOSIS—R. D. MASON, M. D., Omaha, Nebraska 109
SCHOOL SANITATION AND MEDICAL INSPECTION OF SCHOOLS—E. E. DORR, M. D., Des Moines, Iowa 541
STATE HOSPITAL AT CHEROKEE, A VISIT TO THE—EVALENE PEO, M. D., Boone, Iowa 596
STATUS LYMPHATICUS—JAMES MAYNARD, M. D., Adair, Iowa 72
STOMACH, ACUTE DILATATION OF THE—CHAS. BURNSIDE, M. D., Des Moines, Iowa 33
SURGICAL PSYCHOSES WITH REPORT OF TWO CASES FOLLOWING OPERATIONS—A. P. STONER, M. D., Des Moines, Iowa 246
SURGERY, CLINICAL BRIEFS IN—C. E. RUTH, M. D., Des Moines, Iowa 250
SYMPOSIUM ON SHOCK, A REPORT ON THE—W. L. MENDENHALL, M. D., Des Moines, Iowa 357
SYPHILIS, LATE INHERITED—E. R. POSNER, M. D., Des Moines, Iowa 289
SYPHILIS, THE IMPORTANCE OF THE WASSERMAN REACTION IN THE DIAGNOSIS AND TREATMEMNT OF—WM. E. SANDERS, M. D., Des Moines, Iowa 283
TONSILLAR AND ADENOID AFFECTIONS OF SCHOOL CHILDREN—F. E. V. SHORE, M. D., Des Moines, Iowa 530
TUBAL STERILIZATION—L. W. LITTIG, M. D., Davenport, Iowa 105
TUBERCULINS AND THEIR INDICATIONS—S. R. KLEIN, M. D., New York, New York 78
TUBERCULOSIS, PREVENTION OF—CHAS. J. WHALEN, M. D., Chicago, Illinois 114
TUMORS OF THE MAMMARY GLAND—A. P. STONER, M. D., Des Moines, Iowa 417
TUMORS, THE STUDY OF MALIGNANT—JAMES W. JOBLING, M. D., Chicago Illinois 511
TYPHOID FEVER, SOME UNUSUAL COMPLICATIONS OF—C. P. HOWARD, M. D., Iowa City, Iowa 1
URINE, MICRO-ORGANISMS IN THE—S. R. KLEIN, M. D., Valhalla, New York. 594
VARICOCELE OF THE SPERMATIC CORD, OPERATIVE TREATMENT OF—AIME PAUL HEINECK, M. D., Chicago, Illinois 83
VISUAL MALFUNCTION, THE PATHOGENESIS OF—PERCY R. WOOD, M. D., Marshalltown, Iowa 18
WHO IS TO BLAME—J. H. GOAD, M. D., Ellston, Iowa 338

CONTRIBUTORS.

Adler, L. H., Philadelphia, Pennsylvania 138
Aiken, Joseph M., Omaha, Nebraska.... 507
Albert, Henry, Iowa City, Iowa..... 261
Acher, A. E., Ft. Dodge, Iowa..... 32
Bassoe, Peter, Chicago, Illinois..... 53
Bierring, Walter L., Des Moines, Iowa 91
Bond, Thos. P., Des Moines, Iowa..... 577
Bremerman, Lewis Wine, Chicago, Ill... 271
Brinkman, J. E., Waterloo, Iowa..... 233
Bristow, Luella, Ann Arbor, Michigan.. 41
Burnside, Chas., Des Moines, Iowa..... 33
Darey, J. H., Sioux City, Iowa..... 120
Dorr, E. E., Des Moines, Iowa..... 541
Ely, F. A., Des Moines, Iowa.....38-264
Emmert, Max, Atlantic, Iowa..... 212
Field, A. G., Des Moines, Iowa.....132-535
Glomset, D. G., Des Moines, Iowa..... 307
Goad, J. H., Ellston, Iowa..... 338
Grover, A. L., Iowa City, Iowa..... 412
Guild, W. A., Des Moines, Iowa..... 370
Howard, C. P., Iowa City, Iowa..... 1
Hawley, Donly C., Burlington, Vermont 137
Hazzard, F. L., Pittsburg, Pennsylvania 139
Heineck, Aime Paul, Chicago, Illinois... 83
Hinkle, G. W., Harvard, Iowa.....292-427
Jobling, J. W., Chicago, Illinois..... 511
Kelley, L. E., Des Moines, Iowa..... 591
Kepford, Aretas E., Des Moines, Iowa.. 458
Kime, J. W., Ft. Dodge, Iowa..... 346
Klein, S. R., Valhalla, New York..78-287-594
La Grange, F. C., Denver, Colorado.... 377
Langworthy, H. G., Dubuque, Iowa.... 215
Littig, L. W., Davenport, Iowa.....105-557
Mason, R. D., Omaha, Nebraska..... 109
Maynard, J. H., Adair, Iowa.....72-360
Mendenhall, W. L., Des Moines, Ia. 357-471
Minassian, H. A., Des Moines, Iowa... 316
Newcomber, L. E., Mason City, Iowa.. 81
Parker, R. H., Des Moines, Iowa....196-582
Peck, J. H., Des Moines, Iowa..... 266
Peo, Evalene, Boone, Iowa..... 596
Posner, E. R., Des Moines, Iowa..... 289
Probst, Chas. O., Columbus, Ohio..... 389
Richards, J. W., Mechanicsville, Iowa.. 466
Roberts, F. T., Ft. Madison, Iowa..... 432
Rundlett, David L., Sioux Falls, S. Dak. 220
Rush, W. A., Omaha, Nebraska..... 45
Rust, Josephine W., Grinnell, Iowa..... 437
Ruth, C. E., Des Moines, Iowa....63-250-421
Sanders, Wm E., Des Moines, Iowa.... 283
Schiltz, N. C., Des Moines, Iowa..... 65
Shore, F. E. V., Des Moines, Iowa..... 530
Steindler, Arthur, Des Moines, Iowa.... 140
Stoner, A. P., Des Moines, Iowa....246-417
Stowe, H. M., Chicago, Illinois..... 324
Strawn, J. T., Des Moines, Iowa..... 277
Taylor, C. B., What Cheer, Iowa..... 407
Taylor, Maude, Ottumwa, Iowa..... 330
Turner, M. L., Des Moines, Iowa..... 586
Waugh, Wm. F., Chicago, Illinois..... 134
Weston, R. A., Des Moines, Iowa..... 331
Whalen, Chas. J., Chicago, Illinois..... 114
Wilkins, C. O., Ft. Madison, Iowa..... 436
Wood, Percy R., Marshalltown, Iowa... 18

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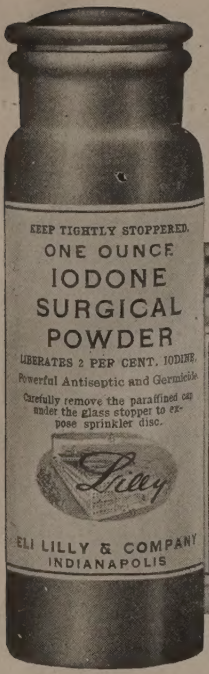

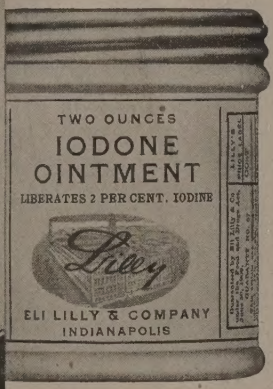

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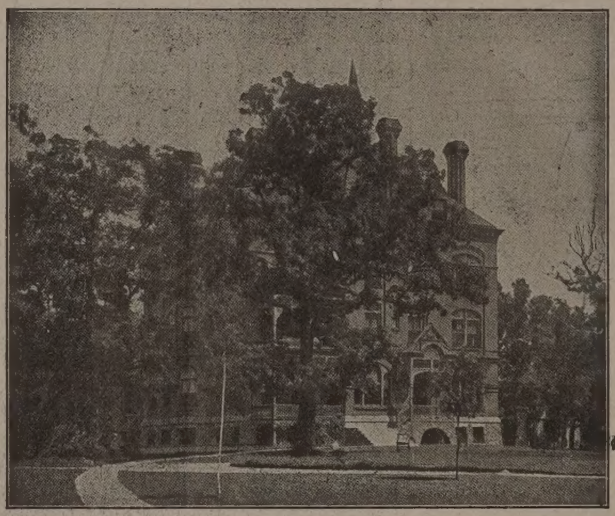

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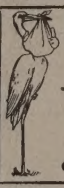

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